HOSPITALS

JOURNAL OF THE
AMERICAN
HOSPITAL
ASSOCIATION

NOVEMBER 1, 1958

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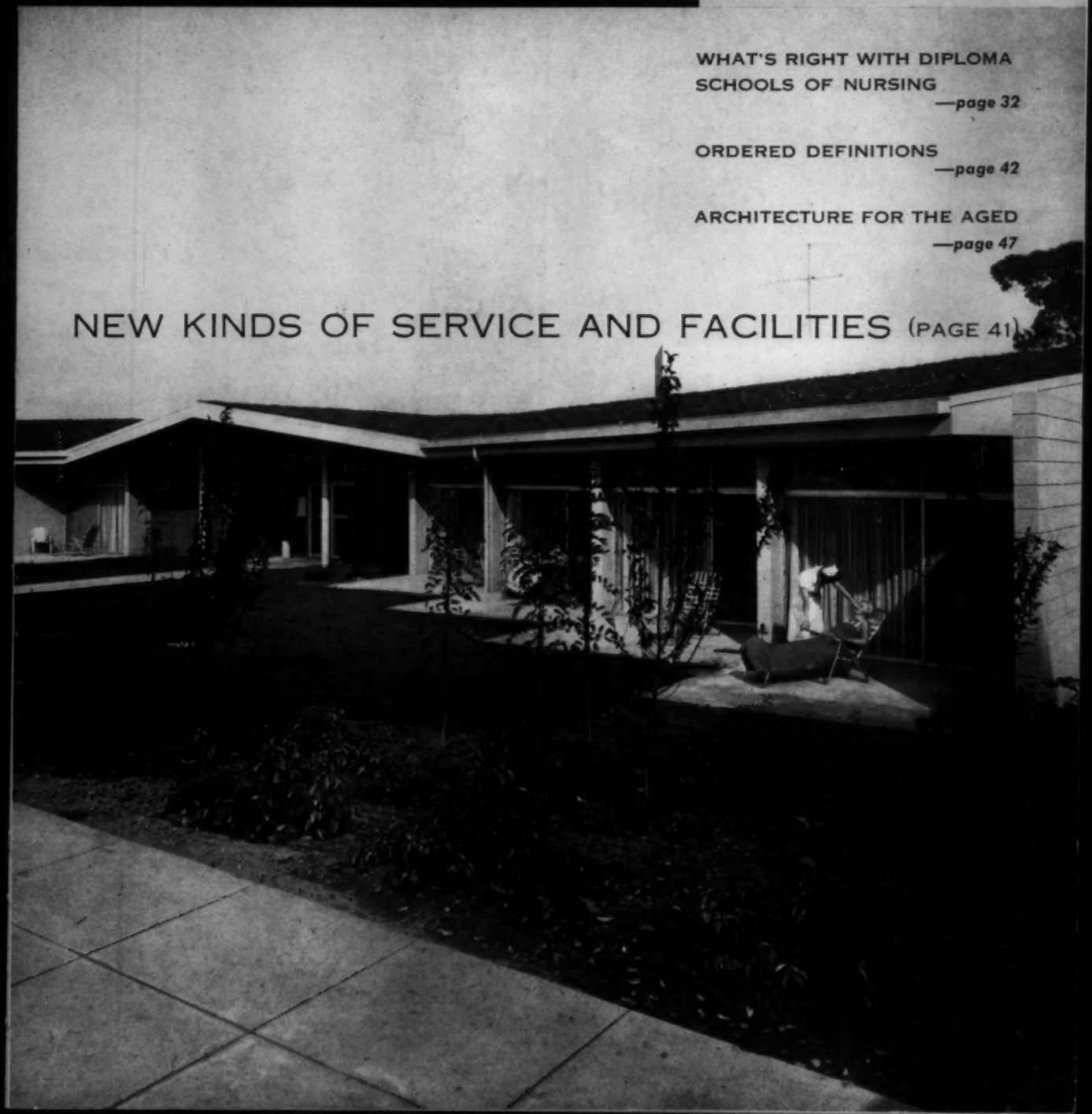

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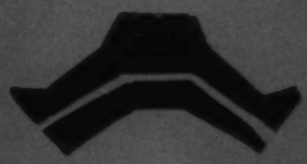

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Front of convalescent wing at Long Beach (Calif.) Community Hospital has individual patios outside of each room for the convenience and comfort of patients. Story on page 41. Photo by Jasper Nutter. (Other picture credits on page 116.)

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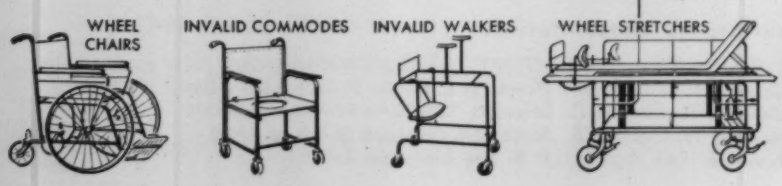

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1959 Annual Convention—August 24-27; New York City (Coliseum; Statler Hotel)

1960 Annual Convention—August 29-September 1; San Francisco (Civic Auditorium)

(THROUGH OCTOBER 1959)

American Protestant Hospital Association—January 27-30; St. Louis (Jefferson Hotel)

Canadian Hospital Association—May 11-13; Montreal (Queen Elizabeth Hotel)

Catholic Hospital Association—May 31-June 4; St. Louis (Kiel Auditorium)

National Association of Methodist Hospitals and Homes—January 27-30; St. Louis (Sheraton-Jefferson Hotel)

REGIONAL MEETINGS

(THROUGH OCTOBER 1959)

Association of Western Hospitals—May 4-7; Salt Lake City, Utah (Utah Hotel)

Carolinas-Virginias Hospital Conference—April 16-17; Roanoke, Va. (Hotel Roanoke)

Maryland-District of Columbia-Delaware Hospital Association—November 3-5; Washington (Shoreham Hotel)

Mid-West Hospital Association—April 1-3; Kansas City, Mo. (Municipal Auditorium; President Hotel)

Middle Atlantic Hospital Assembly—May 20-22; Atlantic City, N. J. (Convention Hall)

New England Hospital Assembly—March 23-25; Boston (Statler Hotel)

Southeastern Hospital Conference—April 8-10; Atlanta (Atlanta-Biltmore Hotel)

Tri-State Hospital Assembly—April 27-29; Chicago (Palmer House)

Upper Midwest Hospital Conference—May 13-15; Minneapolis (Minneapolis Auditorium; Leamington Hotel)

STATE AND PROVINCIAL MEETINGS

(THROUGH APRIL 1959)

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Arizona Hospital Association—November 13-14; Phoenix (Westward-Ho Hotel)

Florida Hospital Association—November 20-21; West Palm Beach (George Washington and Pennsylvania Hotels)

Georgia Hospital Association—March 5-6; Augusta (Bon Air Hotel)

Illinois Hospital Association—December 4-5; Springfield (Abraham Lincoln Hotel)

Iowa Hospital Association—April 23-24; Des Moines (Savery Hotel)

Kansas Hospital Association—November 13-14; Hutchinson (Baker Hotel)

Kentucky Hospital Association—March 31-April 2; Lexington (Phoenix Hotel)

Louisiana Hospital Association—March 5-7; Baton Rouge (Bellemont Motor Hotel)

Minnesota Hospital Association—November 7; St. Paul (Lowry Hotel)

Missouri Hospital Association—November 19-21; Kansas City (President Hotel)

New Mexico Hospital Association—April 10-11; Albuquerque (Hilton Hotel)

Ohio Hospital Association—April 6-9; Columbus (Deshler-Hilton Hotel)

Oklahoma Hospital Association—November 6-7; Oklahoma City (Skirvin Hotel)

Comite des Hopitaux du Quebec—January 21; Montreal (Headquarters of the Comite des Hopitaux du Quebec)

South Carolina Hospital Association—Roanoke, Va. (Hotel Roanoke)

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(Continued on page 108)

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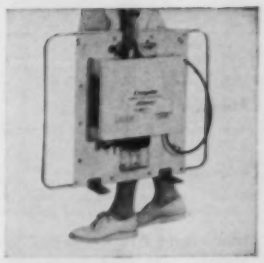

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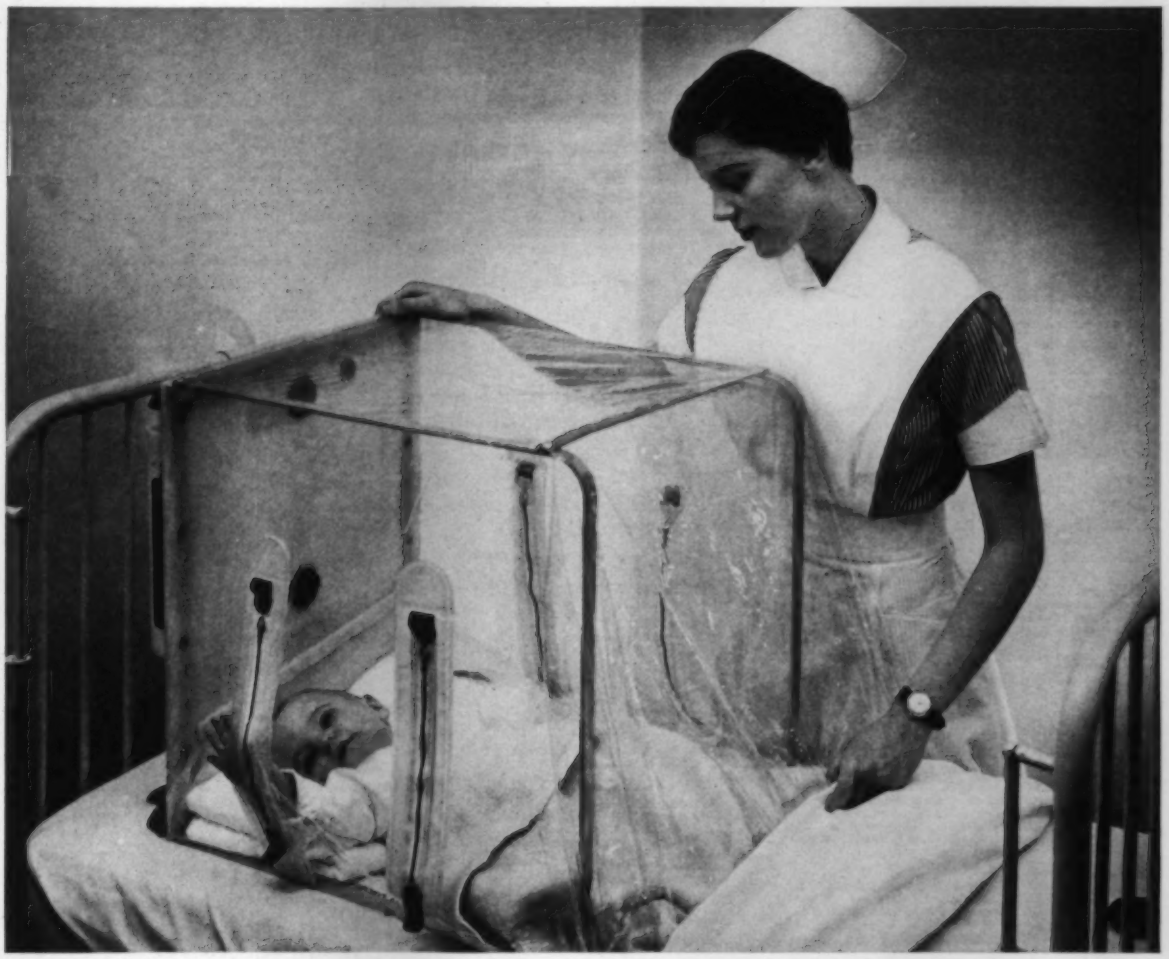

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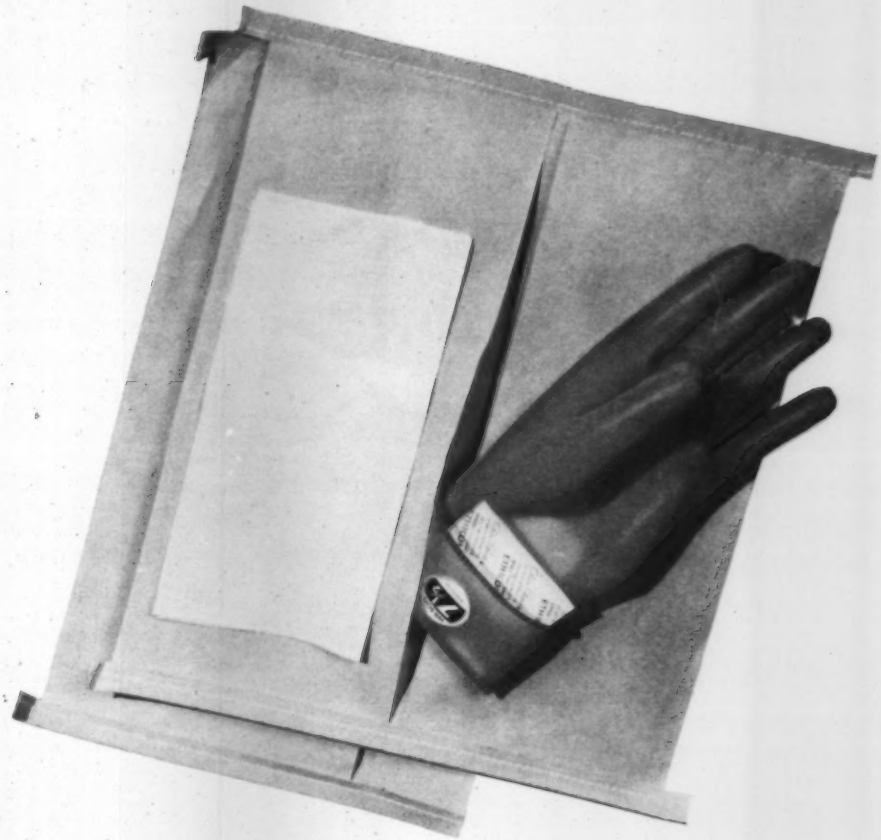

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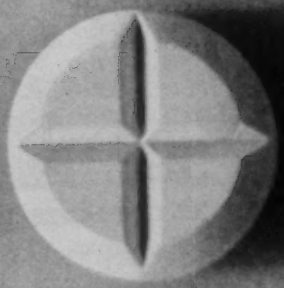

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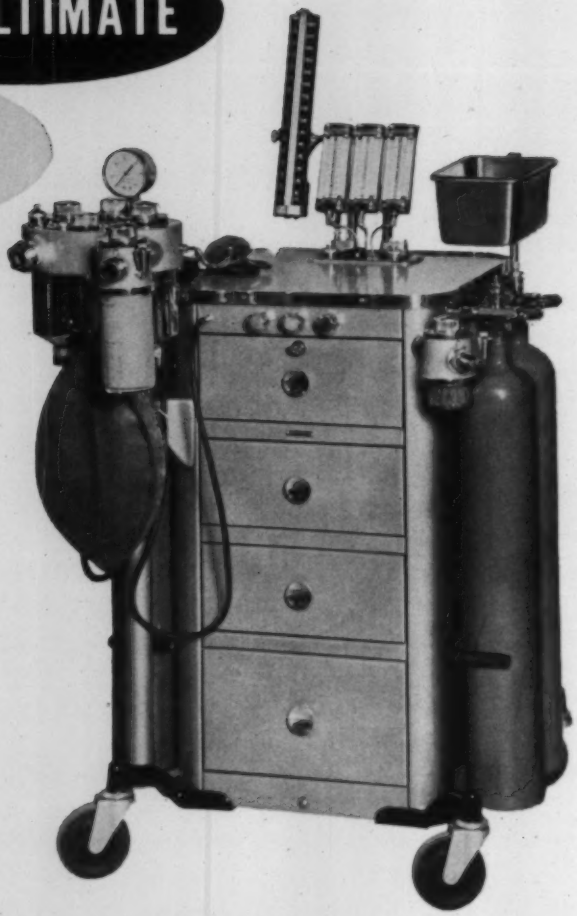

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introducing the authors

John R. Gadd discusses the charge system that has been found accurate and easy to operate at the 100-bed Lee Memorial Hospital, Fort Myers, Fla. He has served as administrator of the hospital for three years.

MR. GADD

Mr. Gadd came to Florida from Tennessee where he had served as assistant director, associate director and later acting director of the Vanderbilt University Hospital, Nashville, from 1950-55. During World War II he served as chief pharmacist's mate in the U. S. Coast Guard.

A member of the American College of Hospital Administrators, Mr. Gadd is a past president of the Middle Tennessee Hospital Council.

He is a graduate of the University of Chattanooga, Tenn.

John D. Thompson, R.N., F.A.C.H.A., research associate at Yale University, studied recovery room case histories of 1500 patients in two teaching hospitals before making the recommendations on recovery room design and operation included in his article on p. 35.

MR. THOMPSON

Prior to joining the staff of Yale in 1956, Mr. Thompson served as assistant director of Montefiore Hospital, New York, for six years. He also served as administrative resident at the hospital after completing the academic requirements for a master's degree in hospital administration at Yale University.

Mr. Thompson completed his undergraduate work at the College of the City of New York and received his R.N. from the Bellevue Hospital School of Nursing for Men, New York.

From 1941-43 Mr. Thompson served as pharmacist mate in the U. S. Navy at Brooklyn (N.Y.) Naval Hospital and aboard the U.S.S. Ranger before returning stateside to duties of medical administration.

He is a fellow of the American College of Hospital Administrators and a member of the American Public Health Association.

Milton W. Skolaut describes how the pharmacist and the purchasing agent can work together in the development of specifications for medical supplies (p. 61). Mr. Skolaut is chief of the pharmacy department, Clinical Center, National Institutes of Health, Bethesda, Md.

MR. SKOLAUT

Mr. Skolaut came to the Clinical Center in 1952 to set up operation of the pharmacy department, after having served three years as chief pharmacist at the U. S. Public Health Service Hospital, Staten Island, N.Y.

Prior to entering the Public Health Service, Mr. Skolaut served as chief pharmacist at University Hospital and instructor in pharmacy at the University of Maryland, Baltimore. He completed his internship and served as assistant chief pharmacist at Johns Hopkins Hospital, Baltimore.

He is a graduate of the University of Texas College of Pharmacy, Austin.

Active in the American Society of Hospital Pharmacists, Mr. Skolaut has served as vice president of the organization as well as a member of the group's Committee on Narcotic Regulations and the Committee on Pharmacists in Government Service.

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Hospital Management Men

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Yet most hospital management men agree that today, in the face of ever-increasing costs, what they *need* are the faster, more accurate facts and figures that office automation can deliver – the up-to-the-minute facts and figures on revenue, patient days, service-department utilization that contribute so greatly to better patient care. But, they ask, how do we get them without undue cost and complexity?

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STEEL UNION CONSIDERS BUILDING OWN HOSPITALS—A special committee of the United Steelworkers of America is to be established to determine the feasibility of setting up a system of hospitals and clinics patterned after those run by the United Mine Workers Welfare and Retirement Fund.

At present the steel union and the steel companies share the cost of health insurance premiums, but under the program which the special committee is to study the employers would pay for the full program.

REPORT FROM WASHINGTON—Blue Cross rates and hospital costs in different parts of the country are scheduled to come under congressional scrutiny. The planned investigation stems from a current study of medical costs, including Blue Cross' role and the prevailing hospital charges in the District of Columbia. Details p. 93.

- The federal government is planning to relinquish control of the practical nurse program in favor of state control of the program. A revised system of distributing funds to the states is also planned. Details p. 93.
- Thirty-nine additional schools of nursing will receive federal funds for graduate nurse training, because of a larger congressional appropriation. Details p. 93.
- The Veterans Administration is spending a record sum on renovation projects this fiscal year, as part of a $70 million spending program. Details p. 95.

PEOPLE IN WASHINGTON

¶ Capt. Leo J. Elsasser has been appointed chief of the Navy Medical Service Corps. He succeeded Capt. Willard C. Calkins, who retired after more than 39 years of active naval service. For the past year Capt. Elsasser has been commanding officer of the Naval School of Hospital Administration, National Naval Medical Center, Bethesda, Md., and a consultant in hospital administration to the surgeon general of the Navy.

¶ Maj. Gen. Oliver K. Niess has been named to succeed Maj. Gen. Dan C. Ogle as surgeon general of the Air Force on Dec. 1. For the past four years, Gen. Niess has been command surgeon of the Pacific Air Forces in Hawaii.

¶ Brig. Gen. Elbert DeCoursey, commandant of the Army Medical School at Brooke Army Medical Center, Fort Sam Houston, Tex., has been promoted to major general. He is a member of the American Hospital Association's Council on Research and Education.

¶ Dr. H. van Zile Hyde has been appointed assistant to the surgeon general of the Public Health Service for international health. Dr. Hyde, who has been chief of the PHS Division of International Health for the last five years, will serve as chief advisor on international health affairs to Surgeon General Leroy E. Burney.

¶ Dr. Abraham Horwitz has been elected director of the Pan American Sanitary Bureau. He is to take office on Feb. 1, 1959, succeeding Dr. Fred L. Soper. Dr. Horwitz is director of the School of Public Health, University of Chile, and assistant director of Chile's National Health Service.

EXPLAIN CAUSES OF RISING MEDICAL COSTS TO PUBLIC: FLEMMING—State public health officials meeting in Washington were urged by Health, Education, and Welfare Secretary Arthur S. Flemming to explain to the public the real causes of rising medical costs.

The Association of State and Territorial Health Officers met with HEW officials Oct. 21-24.

Mr. Flemming said that "we have gotten across to the public" the fact that military weapons cost more today than they did in World War II, but we haven't done the same job in educating the public on health costs. Mr. Flemming pointed out that "very significant breakthroughs" in health have caused health practitioners to use infinitely more costly procedures in health care. He said that it is these breakthroughs and not the general rise in living costs that is the major reason for higher medical care costs.

DISPUTE IN WISCONSIN—The two Blue Shield Plans and the Blue Cross Plan serving Wisconsin have been engaged in a dispute concerning geographical areas of coverage and cost of operation. A report on this situation begins on p. 97.

NOVA SCOTIA JOINS CANADIAN NATIONAL HOSPITAL INSURANCE PROGRAM—On Jan. 1, 1959, the Canadian province of Nova Scotia will become part of the federal hospital insurance program, under an agreement recently signed by the provincial and Canadian governments.

This is the seventh such provincial agreement entered into by the Canadian federal government under the Hospital Insurance and Diagnostic Services Act. The federal hospital insurance programs in five provinces have been in operation since July 1.

In addition to providing insurance coverage for services in hospitals, the Nova Scotia agreement

Worth Quoting

". . . Men are not led by being told what they don't know. Persuasion is a force, but not information; and persuasion is accomplished by creeping into the confidence of those you would lead. Their confidence is gained by qualities which they can recognize, by arguments which they can assimilate: by the things which find easy entrance into their minds and are easily transmitted to the palms of their hands or the ends of their walking sticks in the shape of applause . . ."

—Woodrow Wilson.

provides for, on an outpatient basis, certain laboratory and radiological examinations; use of physiotherapy facilities and radiotherapy facilities for treatment of malignancy, where such equipment is available, and necessary nursing services.

Emergency diagnosis and treatment services are provided for, on an outpatient basis, for 48 hours following an insured's accident. Services include necessary laboratory and radiological procedures for diagnosis and treatment, use of operating rooms and anesthetic facilities, drugs, nursing services, and necessary meals at the standard ward level.

Nova Scotia's share of the program will be financed through a 3 per cent sales tax in the province.

U. OF MICHIGAN TO STUDY SOCIAL FACTORS IN AGING—A grant of $350,000 has been made to the University of Michigan by the Ford Foundation for a study of the economic and social factors affecting the aged. The five-year study, to be directed by Dr. Nathan Sinai, director of the university's Bureau of Public Health Economics, will try to determine, on a nation-wide basis, what the health problems of the aged are and will offer suggestions for an attack on these problems.

GUNDERSEN ASSAILS PIECEMEAL APPROACH TO FEDERAL CARE OF AGED—A warning that congressmen would make further attempts to get approval for legislation aimed at providing hospital-medical benefits for social security beneficiaries was voiced by Dr. Gunnar Gundersen.

DR. GUNDERSEN

Dr. Gundersen, president of the American Medical Association, spoke before the 67th annual meeting of the Association of Life Insurance Medical Directors of America, Oct. 23, in Hartford, Conn.

Dr. Gundersen said that though the bill introduced by Rep. Aime J. Forand (D-R.I.) had not passed Congress, proponents of such legislation may eliminate medical and surgical inhospital provisions and seek only hospital care for social security beneficiaries.

". . . One all-inclusive legislative measure [was sought] a decade ago," Dr. Gundersen said. "When that failed, the proponents began seeking their ends in a piecemeal manner. Now they have publicly announced their intent to break up the pieces into bits, as in the case of the Forand bill, hoping that within a few years enough bits of legislation will be passed to make up one large piece.

". . . Some opponents of national compulsory health insurance may . . . accept a bit of legislation here or there with the hope of appeasing the opposition or of satisfying a particular financial problem for themselves. Let us not be duped . . .

"We must bestir ourselves now and aggressively seek voluntary programs to solve the health care needs of the aged within the pocket-book capacity of the senior-citizen group."

How effective is Blanket Disinfection?

There's little doubt that the hospital blanket which is in such close contact with the patient offers a fertile field for spreading infection. Confirmation by bacteriologic tests usually reveals a surprisingly high count under ordinary blanket use situations.

Efforts to eliminate this reservoir for spreading staph (and other potentially dangerous organisms such as tubercle bacilli) have stimulated controlled studies in many hospitals... and the consequent adoption of routine disinfection of blankets between patients. For example—

In New Hampshire, Adams[1,2] hospital added Amphyl® disinfectant to routine laundering of blankets as patients changed, or earlier if soiling occurred, with the result that "it renders them routinely sterile" and also "this disinfectant neither shrinks nor discolors blankets."

In Washington, Ravenholt and others[3,4] tested Amphyl for disinfecting hospital blankets heavily contaminated with staph. Their findings indicate that "the addition of a synthetic phenolic disinfectant Amphyl achieves virtual elimination of staphylococci on the blankets. Routine use of the tested disinfectant for washing blankets, pillows, and all laundry materials, as well as for surface disinfection, in a Seattle tuberculosis sanatorium for seven years has demonstrated that the disinfectant does not injure fabrics or other materials nor cause sensitivity reactions in personnel or patients. On the basis of these findings, the synthetic phenol used in these studies appears to be a suitable compound for use in blanket disinfection."

Practical problems of laundry handling as well as the bactericidal and tuberculocidal effects of Amphyl have been considered in these reports. We hope you will find each article helpful in making Amphyl blanket disinfection routine in your own laundry. Also, Lehn & Fink's technical staff is always ready to assist you in strengthening control of cross infection in any area of your hospital. Just write us at 445 Park Avenue, New York 22, N. Y.

We will be glad to send these reprints.

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1. Adams, Ralph: Med. Times, 86:1119-1127 (Sept.) 1958.
2. Adams, Ralph: Resident Physician, 4:112-132 (Sept.) 1958.
3. Ravenholt, Otto H., and others: Hospitals, 32:75-80 (June 16) 1958.
4. Ravenholt, Otto H., and others: Med. Bull. U. of Minn. 29:421-429 (May 1) 1958.

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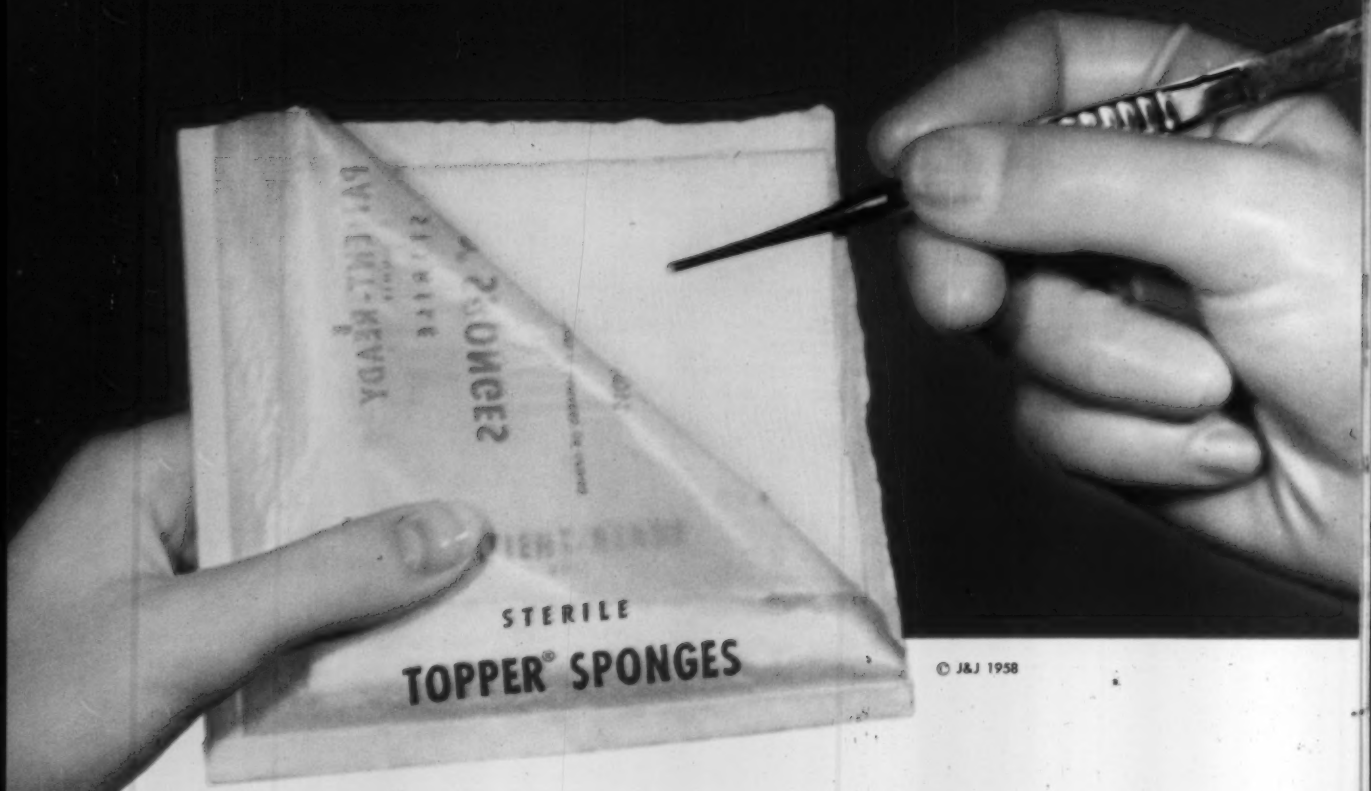

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opinions and ideas

LETTERS TO THE EDITOR

Unlimited visiting in a military setting

Dear Sir:

We read with interest Capt. Leonard Berlow's article on unrestricted visiting (HOSPITALS, JOURNAL OF THE AMERICAN HOSPITAL ASSOCIATION, Sept. 16). May we point out though that there is no more captive group in the world than military patients and that in a well-run military installation there should not be a visiting problem (as a matter of fact, there should not be any problem) because problems are routinely eliminated by direct order or memo.

The situation might be a little different at Wright-Patterson Air Force Base where there are a number of civilian employees but the majority of the personnel in the average military hospital have no relatives in the area so who is there to cause the problem? One or two of their buddies and a visit from the company clerk when there's a payroll to sign?

If there are no worried families to create a problem, then where does the problem arise? With the pediatrics patient, naturally, the only patient in Wright-Patterson Air Force Hospital or in any other military hospital who has a family near enough to bother about him and the only patient whose plight bears any similarity to that of the patient in the community hospital yet after a trial period restricted hours were again put into effect and the only area which needed attention remains the one area which is getting none. The non-pediatrics patient in a military hospital could have visiting around the clock and there would still be no problem.

We'd be interested in knowing how many visitors this Air Force Hospital (which is 10 miles out of town) has in a year and how those figures compare with the volume of visitors which the community hospital in the heart of a large city might have to contend with. As it stands now the article proves only that unrestricted visiting cannot be used except where there isn't any need for it.—CHARLES J. HACKETT, *controller, Hackensack (N.J.) Hospital.*

Editor's note: Mr. Hackett's letter was referred to the author who replied in part as follows:

Dear Sir:

I am sorry that Mr. Hackett feels that Air Force hospitals are without comparable problems to civilian hospitals. I am also sorry he does not understand that Air Force people marry and have families, friends and neighbors just as do civilians. Actually there are many thousands of military personnel stationed on and around Wright-Patterson Air Force Base, and I venture to say that 70 to 80 per cent of this number are married and average two children for each family. In fact, we average 8000 outpatient visits by our dependents each month! In spite of direct orders to the contrary, military people do get sick and when this occurs they want visitors just as do civilian patients. Certainly, these are not limited to the company clerk and one or two buddies, but families and friends as well. Undoubtedly, Mr. Hackett is relating back to his service days when it was quite true that training areas had only a relatively minor number of dependents. This, as I have pointed out, is no longer the case.—CAPT. LEONARD BERLOW, USAF (MSC), *preceptor and registrar of graduate students in hospital administration, Air Force Hospital, Wright-Patterson Air Force Base, Ohio.*

What's your attitude?

Dear Sir:

I am looking for some fellow readers of your Journal working in the field of hospital personnel management who would be willing to take part in a project of potential value to them and their hospitals.

This project revolves around an attitude survey to be directed to hospital department heads and supervisors, asking opinions of various aspects of the personnel function in their particular hospitals.

If enough personnel people are willing, through use of the questionnaire, to hold their services up to critical light, we may have material for a most illuminating study. If not, those who participate will still have sufficient data on hand to plan a campaign of individual re-education, or more hopefully, enough data to warrant giving themselves a pat on the back.

I shall be pleased to forward to any reader of this column a copy of the opinionnaire for review. There is no obligation to participate in the project; those who wish to see the opinionnaire may find it useful personally.—THERESA SELCOE, *personnel director, Mountainside Hospital, Montclair, N.J.*

Found disinfectant effective on blankets

Dear Sir:

There are a few items that I would like to add from our study at Mt. Sinai Hospital to the article, "Eliminating Blankets as an Infection Source" (HOSPITALS, J.A.H.A., June 16, p. 75).

With the assistance of the Department of Microbiology at Mt. Sinai tests have been conducted to check the bacteria static effectiveness on several quaternary ammonium compounds. We have been running tests for several months and, to date, none of these compounds have resulted in the staining of any blankets, sheets, diapers, or towels. There has been no evidence that these compounds cause diaper rashes, bed sores, or skin irritation.

Mr. Thomas Weil and I recently published an article on the effectiveness of these compounds in the July issue of *Institutional Laundry*. Our cost figures were considerably lower than those mentioned in the article published in HOSPITALS. The cost of this precaution against staph infection, using the quantity suggested, would come to about 16 cents per 100 pounds of linen. The cost figure of eight cents per blanket would make such a process rather prohibitive.—FRITZ FIELD, *supervisor of laundry, Mt. Sinai Hospital, New York City.*

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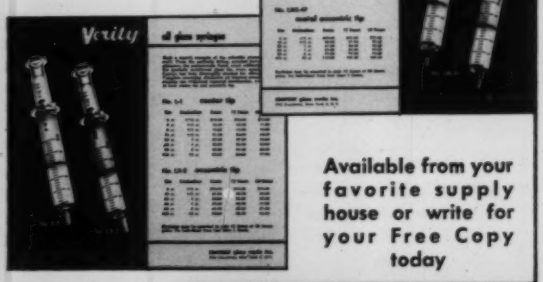

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How many operating rooms

Our hospital expects to expand its surgical department in the not too distant future. Is there a standard ratio of operating rooms to number of hospital beds?

There is no specific ratio of operating rooms to the number of hospital beds which is generally considered a standard. As you know, operating rooms are both expensive to build and to operate. Hospitals are urged to balance the considerations of efficiency with convenience to patients and physicians in making a decision on the number of operating rooms to build.

Another factor to consider is whether all of the operations are to be included in the mornings of five days a week or whether the hospital will staff and utilize its operating rooms afternoons and on Saturdays as well as the limited morning time.

The past experience of the hospital's operating room should be reviewed to determine the average length of operation, the number performed per day, the amount of time needed to clean up after an operation is concluded. When these figures are projected to the number of patients which the hospital expects to serve in a surgical department, it will give a sound estimate for future hospital expansion.—HIRAM SIBLEY

The answers to these questions should not be construed as being legal advice. Hospitals with legal problems are advised to consult their own attorneys.

Autoclaving linens

What causes autoclaved linens to become stiff? Should new linen be washed before autoclaving? Will this lengthen the life of the linen?

The life of linen should not be affected by washing before being autoclaved. However, the autoclaving process could contribute to shortened life if the linen was allowed to become too hot during the sterilizing period.

The autoclaved linen may be stiff if the linen contained a foreign material such as starch filler which becomes dampened during the autoclaving process. This problem may vary depending upon the grade of linen used and will be minimized if the linen is washed before it is autoclaved.

Since the stiffness may be caused by excessive dampening in the autoclaving process, a close check should be made to insure that the equipment is functioning properly and that instructions for the autoclaving procedure are followed closely.

The actual checking of the autoclave and related piping should

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In the manufacture of Zephiran chloride only the finest available grades of raw materials are used. Special manufacturing and purification processes are employed. The finished product is subjected not only to prescribed U.S.P. tests but also to special toxicity and irritation experiments to ensure highest purity and optimal tolerance.

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Supplied: Tincture 1:1000 tinted, tincture 1:1000 stainless, and aqueous solution 1:1000 in 8 oz. and 1 gal. bottles. Concentrate (12.8% buffered aqueous solution) in 4 oz. and 1 gal. bottles.

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be done by a member of your maintenance department.

—G. A. WEIDEMIER

Salary surveys

Does the American Hospital Association publish information concerning salaries of hospital personnel?

During the past 10 years the American Hospital Association has conducted an annual hospital salary survey which covers five major categories: general duty nurses, licensed practical nurses, untrained men, untrained women and clerks. The 1958 survey is presently being compiled and will be published in early 1959.

Information concerning salaries for some categories of administrative and supervisory personnel in hospitals was compiled by the Bureau of Labor Statistics from surveys conducted from 1956 to 1957 in 16 metropolitan areas in the United States. Copies of these reports may be obtained by writing to the Superintendent of Documents, Government Printing Office, Washington 25, D.C. The reports range in price from 20 to 25 cents.—CATHARINE H. LOUCKS

Hospital auxiliary publicity

We are interested in finding information regarding plaques which might be put on equipment purchased for the hospital by the auxiliary. Could you suggest any further publicity for such purchases? We feel our newspaper publicity has been excellent.

In addition to newspaper publicity, the idea of putting a plaque on the equipment purchased for the hospital by the auxiliary is an excellent idea. Another possibility would be to put up a plaque or some sort of exhibit in the hospital lobby which would list all the equipment purchased by the auxiliary. This could be seen by hospital visitors and would, therefore, receive more notice than plaques on the equipment itself.

Auxiliary gifts could also be mentioned in the hospital's employee bulletin. How the equipment is used and its value to the hospital would be interesting follow-ups after the initial story of the purchase.—JANE A. FARRANT

Beds for mentally ill

Is it possible to obtain a grant through the Hill-Burton program to construct additional beds designated for mentally ill patients in a general hospital, also for staffing this addition?

Provision is made for facilities to care for the mentally ill both in the basic Hill-Burton program and within the categories added to the program. Within the total program, therefore, it is possible for a general hospital to obtain a grant for the construction of beds assigned to mentally ill patients and for provision of outpatient services, particularly designed to meet the needs of such patients. The program further provides for structural changes in existing facilities which may be necessary and are undertaken in connection with the development of new and additional facilities.

No federal funds are available to finance staffing or the operation of such facilities. For further details in your planning, contact your state Hill-Burton agency.

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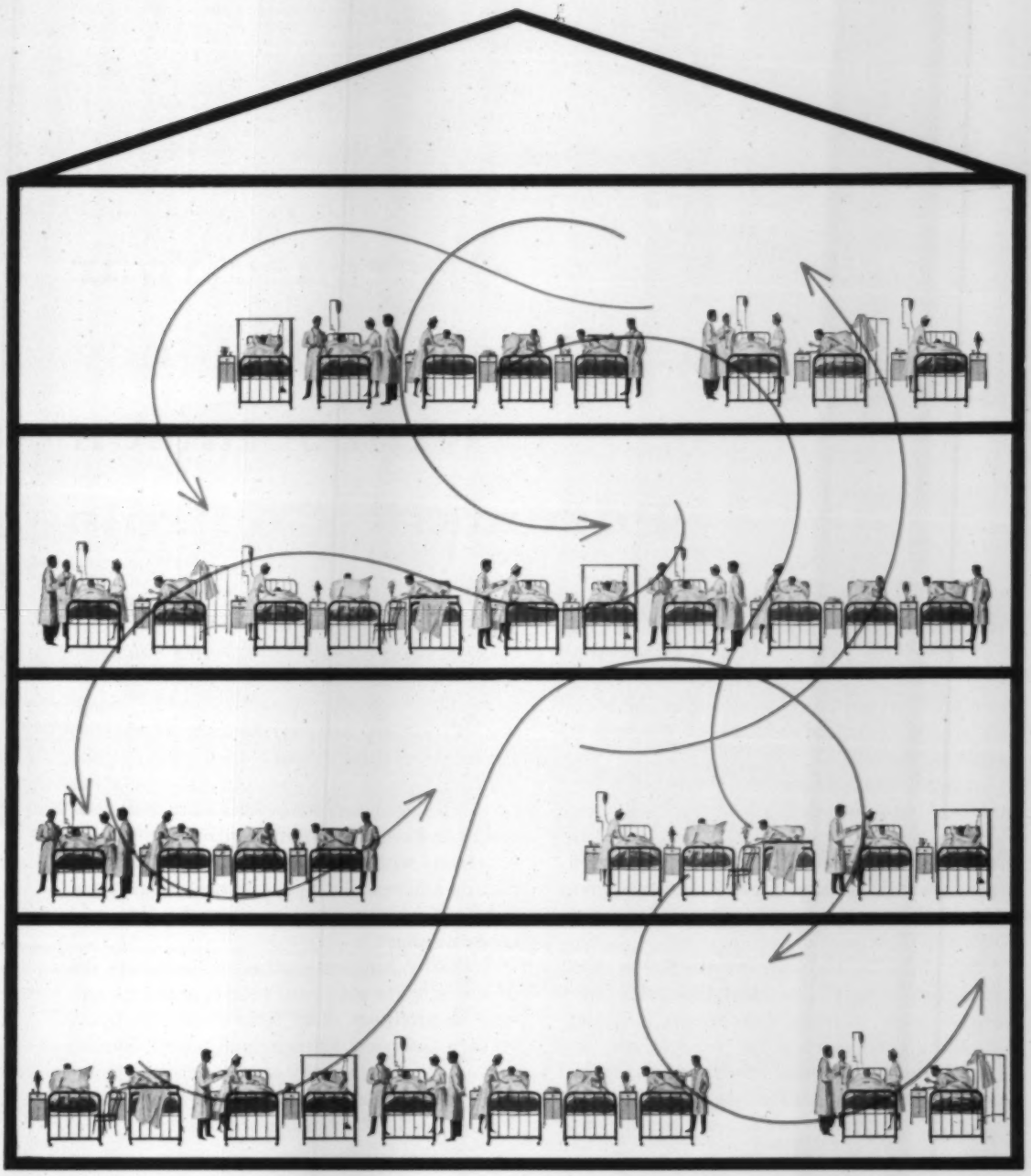

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Mercy Hospital, Fort Scott, Kansas. Schmidt, McVay & Peddle, architects, Wichita, Kansas; Ryan Engineering Co., mechanical engineers, Salina, Kansas; D. C. Bass Construction Company, general contractor, Enid, Oklahoma; Woodhull Plumbing & Heating Co., mechanical contractor, Manhattan, Kansas.

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Provision for the accurate year 'round control of temperatures and humidities is fast becoming a "must" in hospitals everywhere. Mercy Hospital, Fort Scott, Kansas, one of the Midwest's best, is a good example of the way it should be done.

Air conditioned throughout, this outstanding building is equipped with a Johnson Pneumatic Temperature Control System that permits *individual room* control of temperatures throughout the hospital. Operating rooms have the added protection and safety of Johnson Humidity Control.

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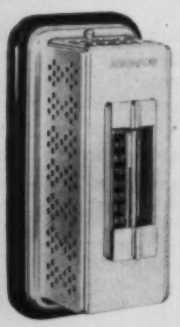

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HOSPITALS
JOURNAL OF THE AMERICAN HOSPITAL ASSOCIATION

editorial notes

—isotopes in the general hospital

Like many awesome products of our atomic age, radioactive isotopes have already demonstrated formidable peacetime applications. Their use in hospitals is rapidly spreading. General hospitals as well as research institutions are finding them effective in both diagnosis and treatment.

As recently as 1952, only 7 per cent of the voluntary nonprofit hospitals listed in our annual Guide Issue had such facilities. Now, six years later, this percentage has tripled. Even more impressive is the fact that 96 per cent of listed hospitals of more than 500 beds in the above category now have such departments.

These dramatic increases only hint at the complications involved in establishing a service of this importance. New personnel had to be recruited and trained. Equipment had to be developed and tested. Hospital procedures and safeguards and necessary administrative details had to be worked out—from scratch, at it were.

For radioactive isotopes, like all potent weapons, must be used properly to insure the safety of those who use them.

One aspect of this safety problem—proper procedures for handling linen contaminated by radiation—is discussed in this issue on page 81.

The larger problem, involving the control and use of these isotopes in the entire hospital, is examined in the recently published AHA "Manual on Use of Radioisotopes in Hospitals."

As its foreword states, the manual is intended to "guide the administrator of the general hospital in the procurement procedures for radioactive materials, in the radiation protection measures necessary for their handling, in the allocation of space and equipment for isotopes laboratories, and in the organization and training of the hospital staff for the utilization of radioactive materials."

This manual, which has been distributed to all AHA institutional members, was prepared by the AHA Committee on the Use of Radioisotopes in Hospitals. Single copies of the manual are available from this Association at $1 per copy.

OFFICIAL NOTES

Actions taken by the Board of Trustees of the American Hospital Association at its meetings in Chicago, August 16-20, are reported in this issue in the Association Section on page 48.

—trick or treat

On the last day of October a seemingly endless caravan of gaily masked waifs trudged door to door in cities large and small, pockets bulging with Halloween booty. Pointed caps askew, blacked-out teeth on view, they sounded their shrill chant of "tricks or treat."

To all but the sternest, the sight of apple-red cheeks and glowing eyes made a "treat" seem small payment indeed.

This year the light steps and hearts of these children had a very special meaning. In the past, thousands of these children would have been claimed by poliomyelitis. The battle against this heartless foe is not yet over, but the end is in sight.

Today scores of hospital wards that formerly housed poliomyelitis patients at this time of year are being put to other uses; wards that but for the Salk vaccine would again be filled with children who now will never know the anguish of a brace or a respirator.

Almost before we know it, Thanksgiving will be upon us. This year, as every year, those in the health field have much to be thankful for.

WHAT'S RIGHT WITH DIPLOMA SCHOOLS OF NURSING

by RUTH SLEEPER, R.N.

In answering the question of what's wrong with diploma schools of nursing, the author reaches the conclusion that nothing is wrong—at least nothing that can't be corrected. She outlines reasons for her belief in the value of hospital-sponsored diploma schools.

TO THE HOSPITALS of the country, the women and men graduating from diploma schools of nursing constitute the very heart of nursing. Often these nurses determine whether hospital beds are available or closed to the public. To the doctor these graduates represent the core of the patient care team. They maintain the patient areas in which student nurses from all types of educational programs receive all or much of their clinical experience.

Why, if all of this is true, does any one question the continuance of diploma programs? Why don't advocates of diploma programs have firm, convincing answers ready when the questions do come? Why do convictions waver when a new form of education for nurses is introduced? Why do many look so eagerly at the new, and so disparagingly at proven programs?

Has someone with an air of strong conviction said recently, "Give up the diploma program. Change to university or junior college"?

Or perhaps someone said "Remember that the National League for Nursing publication, *Nurses for a Growing Nation*, says the degree graduates must increase from 15 per cent to 23 per cent and diploma graduates decrease from 85 per cent to 67 per cent"?

Most people concerned with nursing education believe in university programs. They believe in junior college programs. They also know, however, the above percentages can be misleading. *Nurses for a Growing Nation* contains a discussion of future needs requiring that annual admissions to basic nursing schools rise from the current level of 45,000 to about 70,000. This means that 85 per cent of 45,000 admissions falls short of 67 per cent of 70,000 admissions by more than 8,000 students. What these statistics really say is that annual admissions to diploma schools must be stepped up by more than 8,000.

Often it is those not directly responsible for staffing wards—or for the conduct of a diploma school—who make misleading statements regarding diploma schools. Often those least familiar with the intimate details of supply and demand for nurses criticize diploma schools.

Those who live close to people in hospitals, sick people, close to the various fields of science which serve these people, close to the thousands of nurses who have been graduated from diploma programs, will surely not wish to make hurried, unwise decisions. They must take time to look at their beliefs, methods, and future plans.

This is no small matter. It is a question of upsetting an educa-

Ruth Sleeper, R.N., is director of the school of nursing and the nursing service, Massachusetts General Hospital, Boston.

This article is adapted from a speech presented at a meeting of the Council of Member Agencies of the National League for Nursing's Department of Diploma and Associate Degree Programs, Atlantic City, N.J., June 1958.

This material also appears in the November issue of *Nursing Outlook*.

—a reaffirmation of belief

tional system which has produced nurses for our country for 83 years. The system is assured of reasonable —and often generous—support. It is also a question of giving up a familiar and a much needed system without adequate provision for replacing it. No one really knows how rapidly or slowly other schools could be developed to replace the hospital conducted diploma schools. Nor is it known what proportion of the new programs' graduates would consent to carry the direct nursing care now provided by the diploma school graduates.

ANSWERING THE CRITICS

What is wrong with the diploma program? Many views are given.

Some say, "It is old style." But it is not necessarily senescent unless we make it so.

"It is supported by the service agency," others say. But so in part —though usually in a different way and to a lesser degree—are medicine, physical therapy, pharmacy and several other fields.

The accepted pattern for all education is in a college or university other critics say. But is it wrong to have a variety of patterns? The diploma program in a hospital is admittedly a single purpose school. It lacks breadth of contacts for living and for education which the multi-purpose school in the university can provide. This program, however, attracts many young women and men who could not, or would not, go to college whatever the time, expense, or other requirements might be.

The diploma program is criticized because it differs financially from most forms of higher education, since the student receives certain perquisites for which students in colleges pay. But if the need is for more nurses, and more candidates for nursing can afford this plan of education, shall we deny them and lose this supply for our communities?

"More practice time is demanded of students in some hospital schools than is consistent with good education," is another criticism often raised. But, should an entire system be condemned because one aspect is wrong or because some schools fail to meet their obligations to their students?

If each aspect of the hospital diploma school is analyzed, it is clear that wrong really occurs not because a hospital runs the school but because a school fails to provide a sound educational program. This is just as true when the school under scrutiny is conducted by a university or a junior college.

TWO KINDS OF DISTORTION

Trying to judge the programs of 25, 10, or even 5 years ago by today's criteria is a little like studying a near object under field glasses. The object as a whole cannot be seen, but its flaws stand out so starkly as to make the whole seem imperfect. This is an exaggerated picture and not a valid one. On the other hand, it does not pay to turn the field glass wrong end to, as the child enjoys doing. In this distorted view the whole is seen clearly, but at such a distance that no true judgment can be made. The whole looks perfect. This might be called a sentimental view. It is not a valid one.

Nursing education introduced in the hospital school did make a contribution to the health needs of the people as judged by contemporary criteria. Then came the university school, at first of the affiliation type. These early university schools offered few differences other than the opportunity provided for broader science teaching, a taste of liberal arts study, and some exposure to college life. Then followed the more soundly organized five- and four-year programs.

Unfortunately, hospital schools looked upon these newcomers in the universities as possessing more prestige. It was believed that the university school graduate had greater status. Too often the diploma school, eager to have the best for its students, strove to add everything, or imitate too many of the innovations without regard to differing objectives. The public, and the candidates for nursing, and the hospital family as a whole wanted to know what the difference was between the diploma and the degree programs.

Now there is, I believe, a difference which is of great importance.

Certainly there should be a difference, for one student invests more time, academic effort, and money than the other. Surely, the university program should be worth this added investment. Yet this fact should neither belittle the product nor reduce the value of the investment made in the diploma school.

One difference should lie, first of all, in the purpose of the two programs (diploma and degree) as derived from the philosophies of the schools. Those concerned with diploma programs are agreed, I believe, that they should prepare the bedside nurse. The university school in turn, with its broad opportunities, should prepare for more rapid progress to positions of leadership. Of course, diploma schools will also produce leaders, and these young women and men will seek and enjoy opportunities for college study and, if desired, advanced specialization. However, the basic purpose of the diploma school should remain direct patient care.

NEEDS OF PATIENTS AND STUDENTS

To find our objectives then we would naturally look first at patient needs. As diploma schools are aware of the value of sound teaching methods, they naturally would combine objectives derived from consideration of patients' needs with other objectives which would make the program properly student-centered. Hence the student learns to meet the patients' needs. The outcome is a student who has learned, and patients who benefit because there is a continuing supply of graduate nurses for direct patient care.

Let me illustrate.

- The patient in the hospital is entitled to nursing care which will complement and supplement the medical care plan in such a way as to produce maximum benefit for the patient.
- Nursing service should provide the basic, supportive care necessary for physical and emotional comfort, rest, safety and hygiene for all patients.
- Nursing service should help the patient to move positively from dependency to the maximum degree of independent activity consistent with his medical condition.
- The hospital patient and his family are entitled to know what care is needed after discharge, and to be taught whatever is necessary to encourage maximum recovery, prevent further illness, and attain the best possible family adjustment.
- The patient is entitled to such care regardless of who is to give the care. The nurse guiding the auxiliary workers, therefore, has an obligation—and should be so prepared—to teach the worker and supplement the auxiliary care to make these goals possible for the patient. The degree of comprehensiveness of the care will depend upon the patient's needs. Every patient neither needs nor wants the same care.

Now what does this mean for the nurse graduating from a diploma program? Do the points described above comprise only a technical education? Are mere technicians able to give this care? Of course the nurse must have tools with which to work, mental and physical. Objectives in nursing care can be formulated by a study of the goals of each hospital's care program. Neither objectives nor specific tools can be adopted verbatim from the above points, from a National League for Nursing list, or any other piece of literature. Each hospital's study of its own patient care goals will, however, enable schools to adapt such materials. Wisely adapted they will be helpful objectives and useful tools.

IT'S THE REASON WHY THAT COUNTS

In the preparation of a nurse for direct patient care the study of health and home care should be included. This is done because the patient and family must be taught to provide home care—not because the diploma graduate should be prepared for work in public health nursing. Students in the diploma program learn how to make a referral to the Visiting Nurse Service because continuity of care for the patient when he returns home may be a significant factor in determining whether he gets well and stays well—not because they are to work in the community as public health nurses.

Elements of administration are also included because they are an essential part of good planning which produces more effective care, is more economical of learning time, and more satisfying to a future worker—not because a diploma program is preparing a head nurse or supervisor.

The elements of problem solving will be included, because good care of people involves identification of problems and ability to marshal pertinent facts and select the most appropriate solution—not because the program aims to provide a basic training for graduates to do studies and research.

All these subjects should be presented on the level of a student with the background of sciences and nursing which can be appropriately given in a hospital diploma program, and used by the graduate of such a program in her care of patients.

I believe those of us connected with diploma programs are much to blame for present confusion. We have not spoken with clarity or conviction. We too often incline to copy another program, instead of studying and devising our own. We have too often sought change because we thought the NLN required it—not because we felt it was right. We have wanted too much for our graduates. We have worked hard, but sometimes toward unrealistic goals. Because our plans were inadequate, or unsound, or not well adapted to the particular situation we have had a sense of failure, or frustration or inadequacy. We have lost faith in ourselves and the future of the diploma school.

Diploma schools need today, almost more than ever before, fresh, energetic qualities to combine with maturity of insight. We don't need to perform miracles, but we do need to take what is before us and make it fit the situation. If this is accomplished, diploma programs can prepare the necessary quantity and quality of nurses to assure the American people the direct nursing care they need.

It is time hospitals and nurses together stated their belief in the diploma school. Once this is done, we must study our situations to learn how best to move constructively toward the improvement in the diploma school in which we have together reaffirmed our belief. ■

'SHORT-STAY' AND 'LONG-STAY':

STUDY OF TWO RECOVERY ROOMS OFFERS CLUES TO INTENSIVE CARE UNIT DESIGN

by JOHN D. THOMPSON

Postsurgical recovery rooms fall into two distinct categories, the author finds: postanesthesia and postoperative units. He discusses the influence of these differing types on (1) recovery room design and operation, (2) ratio of recovery beds to operating rooms, and (3) possible relationship between recovery room and minimal and intensive care units.

CONCENTRATED, skilled treatment of postoperative surgical patients in specially designed recovery rooms is now an accepted method of care in many general hospitals. The extension of this service to nonsurgical patients as well and its expansion to include the entire "danger period" of the patient's hospital stay is receiving serious consideration by physicians and hospital planners. An inquiry into the operation and function of the recovery room, therefore, is not only of value in elaborating design criteria for future recovery rooms, but it might give some assistance in predicting possible operational patterns of intensive care units.

The first step in obtaining design criteria for any hospital unit from its function is a detailed determination of that function. In order to accomplish this, quantitative evaluation was made of the recovery room histories of 500 patients in Hospital A and 1000 patients in Hospital B. The evaluation covered length of stay, services rendered, diagnoses and personal characteristics of the study patients.

These particular hospitals were selected because the formal policies of both surgical divisions state that all patients who have received a general or spinal anesthesia are to be admitted to the recovery room (if it is open) before returning to the inpatient unit. Within this policy the hospitals operate two main types of recovery room, i.e., the short-stay unit in Hospital A and the long-stay unit in Hospital B.

The short-stay recovery room is open 10 hours a day, five days a week. The unit in Hospital B operates 24 hours a day, seven days a week. Based on these operating policies, two different functions can be delineated by analyzing the data obtained from the medical histories of the two groups of patients.

The average length of time a patient stays in the recovery room is a valuable indicator of the type of care given to patients in that unit. There is evidence that at least two factors influence the length of time a patient spends in either recovery room: (1) the surgical procedure performed on the patient and (2) the time he is admitted to the recovery room.

An analysis of average recovery room stays for each of the two study units, subdivided by diagnostic category and time admitted to the two units, clearly delineates the functions of the two different types of recovery room into the short-stay (a postanesthesia recovery room) and the long-stay (a postoperative recovery room).

The postanesthesia recovery room limits the stay of the patient, in most instances, to the time that he is reacting from anesthesia—a period averaging approximately two hours. The postoperative recovery room has a greater over-all average length of stay (eight hours) due to the added function of providing postoperative care beyond the time the patient is reacting from anesthesia. This postoperative care is given to most patients undergoing certain specified surgical procedures (for ex-

(Continued on page 51)

John D. Thompson is Research Associate, Yale University, New Haven, Conn.

The study described in this paper is from the Department of Public Health, School of Medicine, Yale University and Grace-New Haven Community Hospital, New Haven, Conn. It was conducted under U.S. Public Health Service grant W53C. The assistance of the Surgical Division of Montefiore Hospital, New York, is gratefully acknowledged.

THESE SMALLER HOSPITALS DO A 'TELLING JOB'

8-HOUR HIGH SCHOOL DAY DRAMATIZES THEME OF NATIONAL HOSPITAL WEEK

by ROBERT P. LAWTON

DANBURY HOSPITAL celebrated National Hospital Week this year by inviting selected senior high school students to run the hospital for a day. We felt that this was an effective way of dramatizing this year's theme, "Careers That Count." Although teen-agers had been running town governments and police departments on one occasion or another for years, we knew of no other instance in which they had run a hospital.

Fifteen positions—administrator, assistant administrator, and department heads—were filled by students for the day. Only four departments in the hospital's table of organization were omitted where the nature of the function did not seem to lend itself to this exercise. For obvious reasons the roles of various physician directors were excluded.

Young men were chosen to fill the positions of administrator, assistant administrator, chief x-ray technician, chief laboratory technician, chief engineer, laundry manager and accounting manager. Young ladies took the place of the director of nursing service, chief dietitian, chief physical therapist, chief pharmacist, chief admitting officer, medical records librarian, social service director and executive housekeeper.

SCHOOLS COOPERATE

The response from the principals of the five high schools in the Danbury Hospital service area was enthusiastic. They cooperated fully and chose the students for the various assignments. The hospital merely identified the position to be filled and indicated whether a young man or a young woman was wanted for each post. The number of students chosen from each high school was in relation to its total enrollment. All of the schools were most willing to excuse their students for the day and a half required by the program.

The students were all invited to a two-hour meeting on the morning of Friday, May 2. At this time they were introduced to the members of the hospital staff whose places they were to take on High School Day. Each received a brief description of his "job," received a copy of the hospital's annual report and other literature, heard a brief orientation lecture and had a tour of the hospital. Just before they left, each member of the regular hospital staff made an appointment to meet his student partner in his office on the morning of May 16, the day chosen in National Hospital Week for the students to run the institution. A number of photographs were taken during this orientation period for the purpose of newspaper publicity.

Each day during National Hospital Week our local newspaper, the only daily in our area, published a picture of three of the students and their hospital partners. Each picture was accompanied by an article describing the duties and responsibilities of the particular hospital positions which those students were to fill. From Monday through Friday, all 15 of the chosen positions were thus explained to the public. The weekly papers in suburban towns published similar articles picturing the students from their local high schools. On Saturday the day following High School Day, our daily paper published one full page of photographs as a graphic means of reporting the event.

QUESTIONS INVITED

On High School Day itself, each hospital person had his student partner by his side during the morning to explain both routine duties and emergency decisions. The professionals made a real effort at all times to invite questions from the students and have them express their opinions as to how the hospital's business should be run.

Each member of the hospital staff took his partner to lunch in the hospital cafeteria and the day's program ended in midafternoon after a department head meeting conducted by the student administrator.

In the department head meeting, the appropriate students gave reports on (1) operating finances for the past month, (2) the prog-

DURING Danbury Hospital's high school day, this student learned the importance of proper medical records from the chief medical record librarian (center) and the physician chairman of the medical records committee.

Robert P. Lawton is administrator, Danbury (Conn.) Hospital.

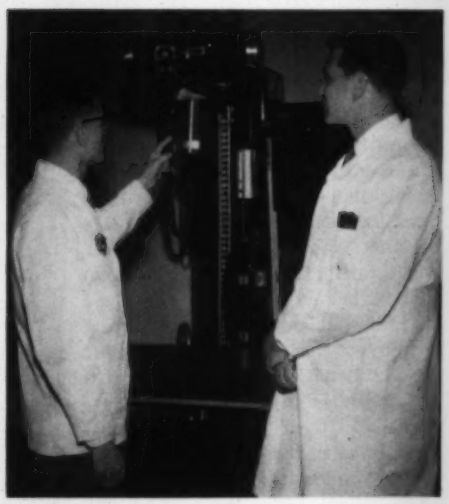
ON TEEN-AGERS

ress of our new building construction, (3) attendance at a training institute for the housekeeper, (4) a description of a plan under which our employees would bus their own dishes in the cafeteria and (5) the parking problem. Except for the fact that the students were, of course, prepared and coached by their partners, they made these reports and carried out discussion by themselves.

The department head meeting closed with each student reporting what he had learned and what his activities had been earlier in the day. The hospital staff had a good time and got just as much done as they would have on a routine working day. The students were so extremely pleased that they spontaneously and unanimously recommended that this program be carried out by the hospital each year.

Many reports have reached the hospital that the high schools buzzed with talk about the interesting and educational experience the 15 students had undergone. ■

THIS student, who will become the hospital's chief x-ray technician temporarily, is introduced to the workings of the diagnostic x-ray machine before he assumes the duties assigned to him during the high school day.



PRACTICAL experience plays a big part in Belmond Hospital's apprenticeship program, which is designed to interest young people in health careers. Here, a student learns to use the spectrophotometer under supervision of a medical technologist.

8-MONTH APPRENTICE PROGRAM IS BASIS OF LONG-RANGE RECRUITMENT DRIVE

by STUART KUTZ

IN OUR SMALL town, recruitment of professional personnel is very difficult. There are few inducements to attract such people to the community. The employee pool consists of those people who have home ties in the area—mostly married women.

There's not much chance of doing anything about the inducements. A town of 2500 can't provide the recreational, social, educational, and vocational opportunities of a metropolis.

Our only course of action is to increase the percentage of local population with technical training. Experience has shown that about 10 per cent of the girls who have left this community for nurses' training, for example, have returned to marry a hometown boy, or spend at least two years in the home hospital before getting married. We decided, therefore, that if we could get more students from the area to train in the paramedical fields, our employee pool would eventually benefit.

We are accomplishing this by what we call our apprentice training program. This program brings a chosen group of seniors into the hospital on a weekly basis to observe, and where possible work, in the department of the individual's choice. It includes general hospital orientation classes for the group as a whole, and field trips to institutions in the health field. We make no pretense of training the students for a job, but we try to let them see what hospital jobs are like. We can prevent students going into the wrong field as well as steer them to one in which they will be happy.

PREPARATION

To be effective, the program must be well organized, and the staff of the hospital completely sold on the idea. For hospitals contemplating a similar program, it's a good idea to start out small, as

Stuart Kutz is administrator, Belmond (Iowa) Community Hospital.

ANOTHER important part of the training program consists of informal lectures on various topics pertaining to hospitals in general or Belmond Hospital in particular. Here, the administrator explains the use of the "break-even chart" in selling charges.

we did, with just one department participating, (usually nursing is easiest) and then expand into the other departments.

The publicity for each year's program occurs in late spring before school is out. A mass meeting day is selected and the local newspaper helps with timing the publicity for most effectiveness.

A direct mailing to all high school juniors inviting them to the meeting helps to arouse enthusiasm. This year the response was great enough to warrant using the high school to help with the program.

A reservation system for the mass meeting was used last year to give us an idea of the expected attendance. The meeting itself was a panel discussion with each department head answering questions prepared in advance. Questions were designed to give a picture of the duties and responsibilities of the people who work on a job, and the training the position requires. The question and answer format provides an informal atmosphere and permits department heads, who might be unwilling to give a formal presentation, to speak.

SELECTION

At the close of the meeting, applications are not accepted since the parents' signatures are required. (The application is also a release by the parents.) Students are asked to mail or deliver applications to the hospital.

Screening of applicants is performed in part by the school and finally by testing to eliminate all but four students in each category. Final selection is made by the department head in the applicant's selected field.

TRAINING

The training program consists of observation and actually assisting under supervision in the department of choice each Saturday for a full eight hours. For one of these hours, the group meets together for orientation lectures* and assignments.

Each group meeting consists of a half-hour lecture on one facet of hospital operation in general or ours in particular, reports on assignments in reading, discussion of reports, and assignments for the following week. Reading assignments are from current hospital periodicals.

At least once each month, tours are arranged at other hospitals or related institutions. These have included: the Blue Cross home office in Des Moines, the Mayo Clinic at Rochester, Minn., Public Health Center at Rochester and several hospitals in the vicinity.

The tours, when possible, have been on a week day and permission was obtained to excuse the students from school. This is an important factor in stimulating general interest among the other students in high school. Often participating students are required to make reports to the student body, and the prestige of the program is enhanced.

Expenses, consisting chiefly of mileage for field trips, have run about $10 a month for the 8-month course.

*Sample copies of some of these lectures are available from Belmond (Iowa) Community Hospital.

RESULTS

The advantages of the program have turned out to be greater than we anticipated. The primary purpose of the program was to increase the number of students taking training in health fields. At the completion of our course in April, 40 per cent of our apprentices had completed arrangements to start training in the fall. This was gratifying, of course, but we also reaped a harvest of employee morale and public relations. The employees are noticeably "on their toes" when they know they must be examples to the students. Students and their parents are goodwill ambassadors for the hospitals as they understand our problems. ■

COMBINATION CHARGE AND CHART FORM SPEEDS UP – AND SIMPLIFIES – THIS CHARGE SYSTEM

by JOHN R. GADD

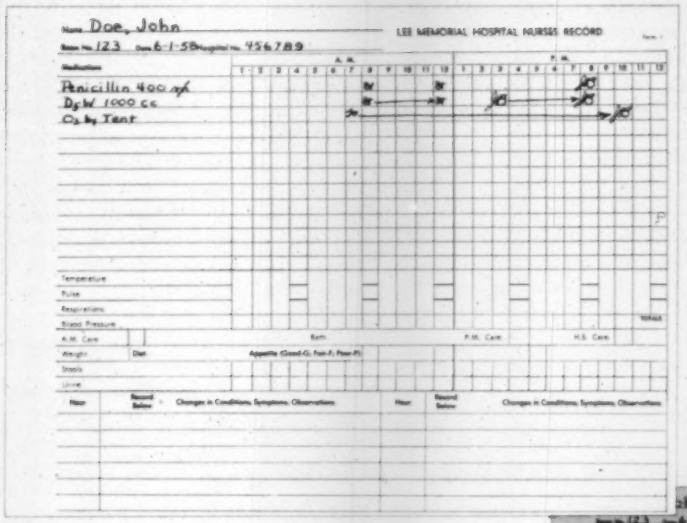


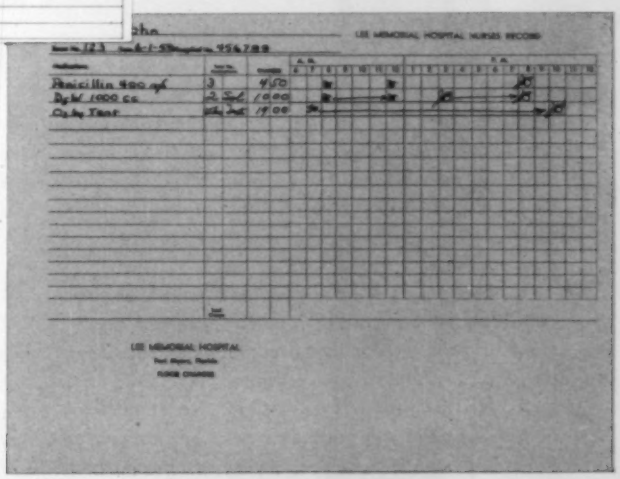
Fig. 1

The author describes a charge system used at 100-bed Lee Memorial Hospital which has proven both accurate and simple. Based on a combination nurses' report and charge form, the system eliminates duplication in nursing, admitting, and business departments, states the author.

A HOSPITAL'S METHOD of communicating charges from the nurses' stations to the business office must be accurate. If each service act and each item of supply for which the hospital has established a charge is being posted to the patient's ledger account, the charge system is functioning and producing an accurate gross income picture.

Such a system, however, may become complicated, cumbersome, and expensive. At 100-bed Lee Memorial Hospital, a charge system has been developed which combines accuracy with simplicity. To institute this charge system, a nurses' record form was designed (Fig. 1). The use of this form:

- Simplifies the work of the nurse.



COMBINATION nursing report forms and charge sheets are maintained for each patient at Lee Memorial Hospital, Fort Myers, Fla. The original (left) is kept with other forms comprising the patient's chart. The carbon (right) is sent to the pharmacist who enters the charges.

John R. Gadd is administrator, Lee Memorial Hospital, Fort Myers, Fla. The charge system described in this article is adapted from a system in use at Vanderbilt University Hospital, Nashville, Tenn., where Mr. Gadd was formerly acting director and associate director.

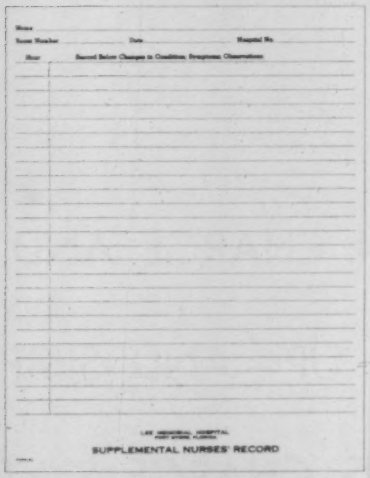
• Combines into one operation the writing for both medicolegal (charting) and charge purposes.
• Eliminates duplication in nursing, admitting, and business departments.

The use of the nursing report form at Lee Memorial Hospital does eliminate the traditional nurse's note form. The nurse, however, cannot be relieved of the responsibility of recording what she administers to the patient, the time it is administered, or what she observes visually or empirically.

The nursing report form is a recording or work sheet for nursing activity. One form for each patient covers a 24-hour period beginning at one a.m. and extending to 12 midnight. On admission or at midnight a form is identified for each patient. The original is maintained with all other forms comprising the patient's chart. The carbon is detached and a designated person enters on the carbon the charge for each item. At Lee Memorial Hospital, the pharmacist enters the charges. When he is off duty, a clerk in the business office takes over the task.

For some postoperative patients, more space is required for "changes in condition; symptoms; observations." In this event, the supplemental nurses' record is used, no carbon being required (Fig. 2).

Here is how the nursing report form is used for charting purposes:


SUPPLEMENTAL NURSES' RECORD

IN THE event more space is required for noting "Changes in Conditions; Symptoms; Observations" this supplemental nurses' record is used, no carbon being required.

If the physician orders, for example, one injection of penicillin to be given four times daily, the nurse records the name of the medication only one time and initials in the appropriate time square. When other injections, such as intravenous solutions, are ordered, the nurse initials the time square which corresponds to the hour when the injection was started. More than one may be started per day. In the same manner oxygen may be recorded and charged (if an hourly rate is used) by an arrow symbol. The arrow begins within the appropriate time square and ends when oxygen is discontinued.

Each note recorded on the original is transferred to the copy to facilitate charging or pricing. On the copy page, however, columns for hours 1 a.m. through 5 a.m. are sacrificed for the columns "Total number medications" and "Charges" (as shown in Fig. 1). Relatively few medications are given during these hours. When recordings are made in these spaces, the person figuring the charge can make adaptations. After the pricing is completed, the carbon copy is separated at the perforations for ease of handling by the posting-machine operator.

The nursing report form cannot, of course, replace all charge slips. Personnel in the operating room, delivery room, x-ray, and laboratory must complete service charge forms and submit them daily to the business office. The use of this charge system does, however, (1) eliminate the purchase and maintenance of equipment that would otherwise be employed in cutting identification plates; (2) eliminate making a charge ticket for every chargeable item; (3) enable all pertinent medicolegal information to be properly recorded on the patient's chart; and (4) reduce late charges to a minimum since the form comes with the patient to the cashier's window and items administered since midnight can be priced at that time and full settlement can be made with the patient. ■

HOW TO RECOGNIZE A DELINQUENT ACCOUNT

The hospital's recognition of the first signs of delinquency in hospital accounts is of major importance, because of the declining value of the collection accounts. The older an account becomes the less likelihood the recovery. The first step toward the solution, therefore, is the adoption of a policy that will permit early recognition of the problem account. Some of the important indications of a delinquency to watch for are:

1. Length of time since last payment was received. If the hospital has not received a payment or valid explanation for more than 30 days, the account should be investigated.

2. Nonpayment excuses. Statements of holders of delinquent accounts and the real reason for nonpayment are seldom the same. The hospital should determine factually the reason for nonpayment. Is the debtor really unemployed? Have there been difficulties in his family? Has he really moved, changed jobs or been ill?

3. Paying habits of the delinquent. How is the debtor paying other bills? The hospital should check the files of a collection service agency, other known credit sources, the attending physician or surgeon to see whether the delinquent is sincere or running away from just debts.

In handling delinquent accounts, the hospital should remember delinquency in paying medical accounts is not a barrier to extension of commercial credit. It has been proved, moreover, that a person may be prompt in paying commercial indebtedness but delinquent in paying his medical expenses.—JAMES V. DEVINE, *administrator, Wesson Maternity Hospital, Springfield, Mass.*, and WILLIAM F. JONES, *owner manager, Hampden Reporting Service, Springfield, Mass.* ■

PATIENT LOUNGE (above) is furnished with modern sofas and chairs covered in vinyl plastic. Table tops are of formica so that patients may eat meals in this area, as well as entertain guests. Nursing units (right) are equipped with an intercommunication system that enables patients and nurses to talk directly to one another.

NEW KINDS OF SERVICE AND FACILITIES

for contemporary convalescent care

by HOWARD B. HATFIELD

THE NEW 50-bed convalescent wing added to Long Beach Community Hospital is one of the first units of its kind to be operated in California.

The unit, which received its first patients in June of this year, was designed to meet the needs of convalescent patients who do not require the complete full-time services which the hospital provides. Such patients, however, often require a degree of care which only a trained staff can give.

The convalescent wing is not operated as a nursing home. There are no direct admissions to the unit. All patients are first admitted to the acute section of the hospital and their cases evaluated. Many of the patients who require the long-term care for which the convalescent wing is designed are heart, fracture or carcinoma cases.

In planning the building it was estimated that 50 per cent of the patients would be ambulatory. With the patients able to do many things for themselves, the nursing staff needed is smaller than in an acute hospital with the same number of beds. With 70 per cent of all hospital costs going into the payroll, the reduction in personnel means that rooms in the convalescent wing cost the patient $2 a day less than similar accommodations in the main part of the hospital.

One of the many unusual features of the building is the private patio outside each patient room (cover photograph). The patio is separated from the room by a sliding glass door and a screen door. When weather permits patients may have their meals served on the patio.

The convalescent wing's schedule differs from that in the main hospital. Shifts in the building are from 8 a.m. to 4 p.m.; 4 p.m. to 12 midnight; and from midnight to 8 a.m. Meals in the unit are also later than in the main wing of the hospital. Breakfast is served at 8:30, lunch at 12:30, and dinner at 6. Patients are not awakened in the morning. When they do wake up, they are brought coffee and fruit juice plus a copy of the morning paper—courtesy of the hospital.

The building consists of three wings with 25 two-bed rooms. There is a large combination lounge-dining area. One entire wall is glass affording a hillside view. Patients may have their meals in the lounge if they wish and may use it to entertain visitors. Visiting hours are from 11 a.m. to 8 p.m. The lounge is closed to the patients at 10 p.m.

Wall-to-wall nylon carpeting is used in both the lounge and the corridors. Nylon was selected for wearing and cleaning features. It was clipped, however, to retard germ growth and to avoid excessive wear by carts and wheelchairs.

In the corridors, on both walls, are handrails. Safety handrails have been installed in all showers, bathrooms and in the sitz bath room. The building has been designed so that all corners are formed at an angle—no square corners.

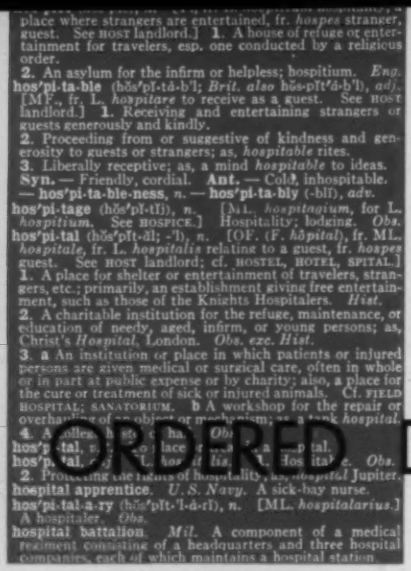
The upper walls of corridors are a light green. Lower walls are a dark green vinyl material. All rooms are light green on two walls. The third wall is covered with wallpaper—with color and design varying from room to room. The fourth wall is glass with the sliding glass door opening onto the patio. All ceilings are sound absorbent. Draw drapes also help reduce noise.

All beds used in the wing are electrically raised and lowered. Each patient room also contains two bedside cabinets, two overbed tables, a combination dresser-desk, a wall mirror, an armchair, two floor lamps (with night-light attachments), a bathroom and two closets.

Music is piped into each room, with a pillow speaker for each bed. The patient has five stations to select from. The rooms are wired for television.

The building was built under a Hill-Burton grant with the federal and state governments supplying one-third of the cost each and Community Hospital supplying the remaining one-third. The wing was built and equipped at a cost of $340,000. ■

Howard B. Hatfield is administrator, Long Beach (Calif.) Community Hospital.


place where strangers are entertained, fr. *hospes* stranger, guest. See HOST landlord.] **1.** A house of refuge or entertainment for travelers, esp. one conducted by a religious order.
2. An asylum for the infirm or helpless; hospitium. *Eng.*
hos'pi-ta-ble (hŏs'pĭ-tă-b'l; *Brit. also* hŏs-pĭt'ă-b'l), *adj.* [MF., fr. L. *hospitare* to receive as a guest. See HOST landlord.] **1.** Receiving and entertaining strangers or guests generously and kindly.
2. Proceeding from or suggestive of kindness and generosity to guests or strangers; as, *hospitable* rites.
3. Liberally receptive; as, a mind *hospitable* to ideas.
Syn. — Friendly, cordial. **Ant.** — Cold, inhospitable.
— **hos'pi-ta-ble-ness**, *n.* — **hos'pi-ta-bly** (-blĭ), *adv.*
hos'pi-tage (hŏs'pĭ-tĭj), *n.* [M.L. *hospitagium*, for L. *hospitium*. See HOSPICE.] Hospitality; lodging. *Obs.*
hos'pi-tal (hŏs'pĭt-ăl; -'l), *n.* [OF. (F. *hôpital*), fr. ML. *hospitale*, fr. L. *hospitalis* relating to a guest, fr. *hospes* guest. See HOST landlord; cf. HOSTEL, HOTEL, SPITAL.]
1. A place for shelter or entertainment of travelers, strangers, etc.; primarily, an establishment giving free entertainment, such as those of the Knights Hospitalers. *Hist.*
2. A charitable institution for the refuge, maintenance, or education of needy, aged, infirm, or young persons; as, Christ's *Hospital*, London. *Obs. exc. Hist.*
3. a An institution or place in which patients or injured persons are given medical or surgical care, often in whole or in part at public expense or by charity; also, a place for the cure or treatment of sick or injured animals. Cf. FIELD HOSPITAL; SANATORIUM. **b** A workshop for the repair or overhauling of an object or mechanism; as, a tank *hospital*.
4. A [illegible] *Obs.*
hos'pi-tal, [illegible] place [illegible] pital.
hos'pi-tal, [illegible] L. *hospitalis* [illegible] Hospitaler. *Obs.*
2. Providing the rights of hospitality; as, *hospital* Jupiter.
hospital apprentice. *U. S. Navy.* A sick-bay nurse.
hos'pi-tal-a-ry (hŏs'pĭt-'l-ă-rĭ), *n.* [ML. *hospitalarius*.] A hospitaler. *Obs.*
hospital battalion. *Mil.* A component of a medical treatment consisting of a headquarters and three hospital companies, each of which maintains a hospital station.

ORDERED DEFINITIONS

patient center, paraphysician, parahospital . . .

by DON CHILL and ALAN E. TRELOAR, Ph.D.

What is a hospital?

How do we differentiate a chronic disease hospital from a nursing home?

What services do hospital personnel perform?

An earlier discussion in this Journal[1] ("Sense, or Jabberwocky?") presented a methodology and basic systems for definitions that would answer these and other similar questions. Emphasis given therein to the necessity for a systematized approach to defining (one which is obtainable by adhering to the classical principles first enunciated by Aristotle) well bears repetition here. A definition

(1) must encompass all entities that properly belong in the concept being defined, and in so doing

(2) must provide the basis for establishment of the relationships and differences between the concept being defined and its close relatives, and at the same time

(3) must delineate the essential characteristics of the concept and do so in the light of these aims.

Examination of these principles in application to the problem of definitions for patient centers led to the following conclusions:

(a) that "services" (as a characteristic) could establish both the differences between, and the relationships of, various patient centers at crucial points in systematic definition, and

(b) that "patients" should serve as the vital connecting link for a definitive system for patient centers.

Before definitions for patient centers can be constructed, independent systems for these characteristics must have more detailed consideration.

This article details research completed under a program entitled "Future Needs for Hospital Facilities" of the Hospital Research and Educational Trust. The program is supported by the U. S. Public Health Service, Bureau of Medical Services, as Project W-43, and by the Kellogg Foundation. This publication is endorsed by the Advisory Committee: E. Dwight Barnett, M.D., Ritz E. Heerman, Rt. Rev. Msgr. Donald A. McGowan, C. Rufus Rorem, Ph.D., and Mary C. Schabinger, R.N. The authors are indebted also to Harry A. Nevel, M.D., J. James Raymond, and Edward Johnson for considerable aid in stimulating discussions. The definitions have been recommended for approval by and accepted by the Board of Trustees of the American Hospital Association.

THE SERVICE SYSTEM IN PATIENT CENTERS . . .

The outline:

Medical
- Physician
- Paraphysician
  - *Nursing (multifaceted services)*
  - *Other (unifaceted services)*
- Dental

Paramedical
- Administrative
- Operational
  - *Plant*
  - *Business*
  - Other specialized

Personnel, delineated by the tasks they perform, were shown in "Sense, or Jabberwocky?" to provide a definitive element for the service system in patient centers. It was also made clear the broad interpretation of the term medical[2] was essential to cut through many terminological problems, and that such broad coverage was necessary in the service system. In addition, it was pointed out that the primary definition of *para* (see *Webster's New International Dictionary*[3]) as "alongside of, beside, at the side of" must not be abused. These stipulations, the above outline, and the following definitions will now give a

Alan E. Treloar, Ph.D., is director of research, and Don Chill is research associate, Hospital Research and Educational Trust.

1. HOSPITALS, J.A.H.A., June 16, 1957.

2. *Stedman's Medical Dictionary, Blakiston's New Gould Medical Dictionary, Taber's Cyclopedic Medical Dictionary* (note the use of medical in all these titles), and *Webster's New International Dictionary*, define medical primarily as "pertaining to, or relating to, medicine."

3. Reference to *Webster's New International Dictionary* will be simply abbreviated to "Webster" henceforth in the paper.

complete picture of a definitive "service" system. We proceed now to the definitions themselves.

SERVICES in patient centers are the activities of all personnel affecting patients or personnel (or both).

MEDICAL SERVICES in patient centers are the activities pertaining to medicine that are performed in behalf of patients by physician, paraphysician, or dental personnel.

The phrase "in behalf of" means "in the interest . . . of, for the benefit of" (see Webster). Intrinsic to use of this phrase is understanding that the patient requires such services, for if the *need* or *requirement* is not there the services cannot be in the interest of, nor for the benefit of, the patient.

PHYSICIAN SERVICES in patient centers are the activities distinctive to medicine that are performed in behalf of patients by a physician.

PARAPHYSICIAN SERVICES in patient centers are the activities characteristic to medicine that are performed in behalf of patients by trained personnel other than physician or dental.

DENTAL SERVICES in patient centers are the activities distinctive to dentistry that are performed in behalf of patients by a dentist and those activities characteristic to dentistry that are performed in behalf of patients by his aides.[4]

The adjectives "distinctive" and "characteristic" must be interpreted with the meanings that clearly delineate. Webster states that "*Distinctive* refers primarily to that which marks or distinguishes one thing regarded in its relation to other things; *characteristic*, to that which constitutes or expresses the character or quality of the thing itself, without references to other things." Since we are examining services in patient centers, we must regard "distinctive" as the word that distinguishes physician services from all others. For example, both a nurse and a physician give injections (an activity characteristic to medicine), but only a physician may prescribe such injections (an activity distinctive to medicine).

NURSING SERVICES in patient centers are the activities characteristic to medicine that are performed in behalf of patients by a registered nurse, a licensed practical nurse, nurses' aides, or the equivalents. Nursing services are multifaceted paraphysician services.

"Equivalents" refer to such approved personnel as trained nurses who have not been registered or licensed, persons who have practical experience in nursing, and other professional personnel who may act in a similar capacity as a nurse or fulfill nursing functions.

OTHER (unifaceted) PARAPHYSICIAN SERVICES in patient centers are particularized activities characteristic to medicine that are performed in behalf of patients by personnel other than nursing personnel or their equivalents.

What is meant by the terms "multifaceted" and "unifaceted" in these classes of paraphysician services? Webster defines *facet* as "any of numerous sharply defined views or aspects of one subject or object of consideration." Further, *Webster's New Collegiate Dictionary* (1956), in discussing synonyms for "phase", states that "*facet* stresses one of a multiplicity of sides each of which manifests the central quality of a thing". It is our feeling that a natural division of paraphysician services may be made on this "facet" approach. Nursing services are "multifaceted" in that they cover a range of paraphysician services; services of technicians, therapists, technologists, biochemists, dietitians, and others, tend to be "unifaceted" in focusing on one particularity of paraphysician services.

PARAMEDICAL SERVICES in patient centers are the activities affecting patients or personnel or both performed in conjunction with those activities pertaining to medicine.

ADMINISTRATIVE PARAMEDICAL SERVICES in patient centers are all activities that are managerial in character, including those of physician or paraphysician when so acting.

OPERATIONAL PARAMEDICAL SERVICES in patient centers are all nonadministrative activities that are necessary for the physical operation of the plant and for the business activities of the establishment.

OTHER SPECIALIZED PARAMEDICAL SERVICES in patient centers are all nonadministrative and nonoperational activities performed by specialists in fields that are primarily nonmedical.

This system readily lends itself to the construction of more detailed classifications for specific categories of personnel;[5] but our immediate concern is with the logical unity of our services classification with that for patients.

PATIENTS . . .

Examine the following definitions for patients and note the essentiality to them of services:

A PATIENT is a person receiving physician, dental, or paraphysician services.

An INPATIENT is a patient (other than a newborn) who is given patient-center lodging in receiving physician, dental, or paraphysician services.

A NEWBORN is a patient who is born in an inpatient center (or is so accepted) and is given lodging therein while receiving physician or paraphysician neonatal services.

An OUTPATIENT is a patient who is not given patient-center lodging in receiving physician, dental, or paraphysician services.

For interpretation of "lodging" we depend again on Webster: "Dwelling; abode; esp., . . . sleeping place; quarters".

With these systematic definitions of patients[6] and services, we turn in orderly progression to a patient-center system.

PATIENT CENTERS . . .

The outline:

Inpatient Centers

Hospital

General

Special: specialty field of medicine (psychiatric, obstetrics, etc.)

specific type of disease (tu-

4. Dental services may be divided into "dentist" services and "paradentist" services.

5. It must be recognized that personnel usually perform more than one task. Two broad examples of this were given in "Sense, or Jabberwocky?"

"A supervisory nurse may be performing paraphysician services (medical) when taking care of a patient, and at another time be occupied with administrative services (paramedical) when drawing up schedules for other nurses. Similarly, consider the case of a dietitian: planning a special diet for a patient is a paraphysician service; planning general diets for hospital personnel and patients on a normal diet is a paramedical service". The professions or occupations might proceed in concert from this point to define their own systems. As a tentative example (for nothing more is intended here without intensive study of the problem) a medical social worker might be performing the following paramedical tasks: operational services such as admitting or eligibility procedures, administrative services such as assignment of casework, and specialized services such as those of arranging for financial assistance for the patient. Medical (paraphysician) services might include those of assisting a patient in understanding his treatment so that his anxiety is relieved.

6. The patient system will be further elaborated in a sequel to this article.

'Thank you' — but 'no thank you'

The following excerpts of letters between a hospital administrator and a vendor are one approach to a problem that can become embarrassing to both parties — gifts from vendors. With the coming holiday season, hospitals with points of view similar to Mount Sinai Hospital, Minneapolis, might find the letters a helpful guide for informing local hospital suppliers of similar hospital policy.

Dear Vendor

As the holiday season approaches we wish to clarify purchasing policies relative to gifts to hospital personnel.

Please be informed that it is contrary to our hospital policy for employees, involved in any manner in the purchasing activity, to receive gifts from vendors or their representatives.

We do not ask our many vendors for hospital contributions as we feel the hospital's interests, as well as the vendors', are better served when quality, price, and service are the prime factors.

If you wish to make hospital contributions for any special occasion you are asked to inquire about the Remembrance Funds that the hospital has authorized . . .

Sincerely yours
A. Z. Hamburg
Assistant Administrator
Mount Sinai Hospital
Minneapolis, Minn.

★ ★ ★

Dear Mr. Hamburg

We appreciate your statement of policy regarding holiday gifts. Traditionally, we have never given gifts—preferring to give the best quality, service and value possible.

Each year as our holiday greeting, we do send a limited edition lithographed watercolor print by H. Gilbert Foote to our customers and suppliers. In December we would like to send you our 1958 print to help add a touch of beauty to some room or hall in your hospital.

In closing, I would like to say how we appreciate your policy in regard to contributions. As a relatively small firm, we have a definite program of contributions to our local hospitals and other charitable organizations. However, we are forced to say no to many, many hospitals throughout the country each year. This is awkward but necessary —so we are especially grateful to know of your stand on this matter.

Cordially yours
John R. Hensley
Franklin C. Hollister Co.
Chicago, Illinois

berculosis, contagious, etc.)
Parahospital
General
Special: specialty field (psychiatric, obstetrics, etc.)
specific disease (epilepsy, cancer, etc.)
Dental Inpatient Center
(All inpatient centers are short-term or long-term.)

Outpatient Centers

General
Special: specialty field (psychiatric, obstetrics, etc.)
specific disease (tuberculosis, cerebral palsy, etc.)
Dental Outpatient Center

A PATIENT CENTER is a medical establishment with permanent facilities and medical services for inpatients or outpatients or both.

To services for patients we have made a crucial addition of "facilities". Explicitness demands that we define facilities at once.

FACILITIES in patient centers are those tangible objects—including plant, equipment, and supplies—necessary for the implementation of services.

But what situation do we face if law, such as the "Hill-Burton Act", states that supplies are not considered to be facilities? Is not this conflict over-riding? No, not outside of the specific legislation. Such legal stipulations imposing restrictions are predicated upon considerations that have no bearing on definitions in a general classification system. Whether or not a law stipulates money will be provided for supplies does not determine the validity of classifying supplies as facilities in a patterned knowledge. Webster states that a facility is "A thing that promotes the ease of any action, operation, transaction, or course of conduct: . . .—usually in *pl.*, as special facilities for study". Supplies are therefore clearly facilities, for it is a basic tenet that each definition must encompass all that properly belongs in the concept being defined.

Specific facilities are not named in any definition given subsequently herein. Since facilities are the means for "implementation of services" it follows that when services are called for the facilities necessary for those services must be present. The types and amounts of such facilities must be

set by standards; they do not belong in definitions.

Our consideration of facilities has constituted a pause while traversing another path. Let us now return to the patient-center system and follow that section dealing with inpatient centers.

An INPATIENT CENTER is a medical establishment with permanent facilities and services for patients who are given lodging in receiving physician, dental, or paraphysician services.

CLASSES OF INPATIENT CENTERS . . .

It is important to remember that in a system of classification the definition for each term in the hierarchy depends on the preceding definition. For example, the following definition of hospital includes all the attributes of an inpatient center as specified in the inpatient-center definition. Similarly, the definitions of general hospital and special hospital (see below) must include all that has been defined for a hospital.

A HOSPITAL is an inpatient center with (a) continual physician services, and (b) continuous nursing services (registered or licensed practical, or the equivalent) and other adequate paraphysician services.

Webster reminds us that continuous connotes ". . . without break, cessation, or interruption", whereas continual means ". . . very frequent, often repeated . . . also, occurring at intervals, or at regular intervals". *Continual* physician services, then, are those that are very frequent or often repeated, occurring at intervals; *continuous* nursing services are those that do not cease. There is some latitude for interpretation of continual, to be achieved if desired through setting of standards; but there can be no equivocating with the word continuous.

The "adequacy" of other paraphysician (i.e. unifaceted) services is, of course, also open to specification through standards. According to Webster, "adequate" means "equal to or sufficient for some specific requirement". In allowing for interpretation through standards (e.g. for types of special hospitals) "adequate" thus permits that *no* other paraphysician services may be necessary.

All of the preceding and all of the ensuing definitions may be further amplified through standards set by recognized authority.[7] But it must be recognized that such rules and regulations are not pertinent to the task of defining. A definition completely fulfills its purpose when it meets the criteria of the methodology—in our case, Aristotelian.

A DENTAL INPATIENT CENTER is an inpatient center with its services—including continual dentist services, continuous nursing services (or the equivalent), and adequate dental-aide services—devoted to dental patients.

There are a few dental inpatient centers in the United States that are not connected with hospitals or parahospitals. The system would be incomplete if it did not encompass all possibilities.

A PARAHOSPITAL is an inpatient center with the continuous services of nurses' aides (or the equivalent) who are supervised by a registered nurse or licensed practical nurse (or the equivalent) who in turn is under the direction of a physician.

There is a challenge to tradition invoked by introduction of a new title like parahospital. Is this not just a new word for "nursing home"? The definition of parahospital as given certainly encompasses such inpatient centers as nursing homes, but it also includes sanatoria, various types of infirmaries, and so on, that are neither hospitals nor dental inpatient centers. Nevertheless, might not "nursing home" be logically considered the all embracing term for this class of patient centers?

One authoritative work gives the following list of names for what may or may not pass as nursing homes: " 'Home for the Aged', 'Nursing Home', 'Rest Home', 'Convalescent Home', 'Boarding Home', 'Boarding Home for Incapacitated Residents', 'Boarding Home for the Aged and Infirm', 'Home for the Chronically Ill and Physically Infirm', 'Terminal Care Home', 'County Home', 'County Infirmary', 'Almshouse', 'Custodial Care Institution', 'Welfare Homes', 'Homes for the Indigent Aged', 'Homes for the Aged and Chronically Ill', 'Boarding Homes for Ambulatory Residents', and 'Related Institutions' ".[8]

The report of the Hospital Classifications Conference sponsored by the American Hospital Association in 1953 attempted a nomenclature for nursing and convalescent homes: "a. Nursing homes, b. Convalescent homes, c. Rest homes, d. Homes for the mentally senile, e. Homes for the mentally defective, with patients requiring only nursing care, f. 'Sanitoria', with patients requiring only nursing care, g. Institutions for epileptics, h. Homes for aged sick, i. Almshouses caring for sick people".

Just as these names vary tremendously, so also do the definitions for the particular establishments. It is thus made abundantly clear that the term nursing home has lost all specific meaning. Introduction herein of the generic term "parahospital" is an attempt to delineate as a group those nursing homes and related patient centers that are medical establishments, but not hospitals, by defining them and giving them an appropriate name. It is the concept that is important. Some new word, whether or not it be "parahospital", is demanded. Indeed we use "parahospital" here in nominal form as an abbreviation for "parahospital inpatient center" which name conveys somewhat better the intended meaning of an inpatient center providing services "alongside" those of a hospital. Such condensations are characteristic of language development.

SPECIAL, AS WELL GENERAL . . .

Both hospitals and parahospitals may be either general or specialized, both of these terms being considered broadly with reference to patient conditions. Webster's definitions for general and special, the American Medical Association's listing of specialty fields of medicine, and the medical definitions for specific disease, will serve to clarify the definitions without the

7. The question may well be raised whether a hospital should be obliged by definitions to make its services available for outpatients whenever emergencies or other considerations command such action. This issue again lies at the frontier between definitions and "standards" of operation. Would it be agreed that a medical establishment, fully qualifying as a hospital in accord with the definition given, should cease to be known as a hospital if it did not permit use of its services for outpatients? If so, then what would it be called? Reflections in this vein have persuaded us that this matter of "standards" should be left for resolution at the local level.

8. *Standards of Care for Older People in Institutions.* Section III. National Committee for the Aging of the National Social Welfare Assembly. p. 47. 1954.

introduction herein of a separate system for such patient conditions.

A GENERAL HOSPITAL is a hospital with its services—including those of internal medicine, general (operative and manual) surgery or complicated obstetrical delivery, and x-ray and clinical laboratory—devoted to patients who collectively have a variety of physical or physical and mental conditions.

Surgery may be manual or operative and for purposes of clarification the parenthetical statement "(operative and manual)" was included in the definition. If complete coverage is understood when "surgery" is used without modifiers, it is hoped that eventually the phrase (operative and manual) will be dropped.

This definition was written earlier without any reference to obstetrics, it being believed these services were covered by general surgery. Study of a sample of hospitals in five states (Alabama, Arizona, Arkansas, Delaware, and California) disclosed a number of "general" hospitals that had no services for general surgery but did have those for obstetrical delivery. A projection of the results of this study leads us to believe that the number of such hospitals in the United States may be approximately 70. In order to include these hospitals in a complete system of definitions the stipulated services were extended to include complicated obstetrical delivery. Where such a hospital has services only for normal obstetrical delivery, the hospital should be considered as an internal medicine hospital (see below) with an obstetrical parahospital service; it should not be considered a general hospital.

A SPECIAL HOSPITAL is a hospital with its services directed wholly or chiefly to patients who collectively have conditions related either by a specialty field of medicine or by a specific category of disease.

While we do not propose to define herein any extensive series of special hospitals, the following examples of such definitions may prove helpful.

An INTERNAL-MEDICINE HOSPITAL is a special hospital with its services, including those of x-ray and clinical laboratory, directed wholly or chiefly to internal-medicine patients.

A PSYCHIATRIC (MENTAL) HOSPITAL is a special hospital with its services directed wholly or chiefly to psychiatric patients.

An ORTHOPEDIC HOSPITAL is a special hospital with its services, including those of orthopedic (manual and operative) surgery, directed wholly or chiefly to orthopedic patients.

An OPHTHALMOLOGICAL AND OTOLARYNGOLOGICAL (EAR, EYE, NOSE, and THROAT) HOSPITAL is a special hospital with its services, including those of ophthalmological and otolaryngological (manual and operative) surgery, directed wholly or chiefly to ophthalmological and otolaryngological patients.

A TUBERCULOSIS HOSPITAL is a special hospital with its services, including those of x-ray and clinical laboratory, directed wholly or chiefly to tuberculosis patients.

A CONTAGIOUS-DISEASE HOSPITAL is a special hospital with its services, including those of x-ray and clinical laboratory, directed wholly or chiefly to contagious-disease patients.

A CARDIAC HOSPITAL is a special hospital with its services, including those of x-ray and clinical laboratory, directed wholly or chiefly to cardiac patients.

A PEDIATRIC HOSPITAL is a special hospital with its services, including those of x-ray and clinical laboratory, directed wholly or chiefly to pediatric patients.

Pediatrics is, in fact, the specialty of internal medicine for children. If general surgery is added to a "pediatric" hospital, the patient center then becomes a children's *general* hospital. Children comprise a specific population group which is an overlay to the entire patient center system, for there can be children's orthopedic hospitals, children's psychiatric hospitals, children's cardiac hospitals, and so on.

An OBSTETRICAL (or MATERNITY) HOSPITAL is a special hospital with its services, including those of complicated obstetrical delivery, directed wholly or chiefly to obstetrical patients.

A PHYSICAL-MEDICINE HOSPITAL is a special hospital with its services, including those of physical and occupational therapy, directed wholly or chiefly to physical-medicine patients.

PARAHOSPITALS ARE BOTH SPECIAL AND GENERAL . . .

A GENERAL PARAHOSPITAL is a parahospital with its services devoted to patients who collectively have a variety of physical or physical and mental conditions.

Some college infirmaries, some convalescent homes, and some terminal homes would be appropriately designated as short-term general parahospitals. Many nursing homes are to us examples of long-term general parahospitals.

A SPECIAL PARAHOSPITAL is a parahospital with its services directed wholly or chiefly to patients who collectively have conditions related

(Continued on page 109)

THESE 'PHARMACISTS' COMPOUND HAPPINESS PILLS

Junior members of the Roanoke (Va.) County Red Cross Chapter have found a program that brings joy to many patients in veterans and other hospitals throughout the state. They clip cartoons, jokes, and anecdotes from newspapers and magazines, stuff them into gelatin capsules and place the capsules in apothecary bottles labeled: "Happy Pills—Take One for the Blues". During the past school year these young "pharmacists" compounded 2000 such capsules.—*Adapted from the September 1958 issue of the Red Cross* Newsletter. ■

ARCHITECTURE FOR THE AGED

factors to consider in designing facilities for elderly patients

by CHARLES HAEUSER

HOUSING DESIGNED specifically for the aged has its own set of architectural problems. In planning such housing, the following points should be carefully considered.

Neighborhood: The neighborhood chosen should have a character familiar to the majority of those being housed. It may be urban, suburban, or rural depending on the residents' original environment. Zoning laws should be investigated to be sure the neighborhood will not change substantially in the future. Often, zoning laws should also be appealed in areas where nursing homes are not now allowed. Well designed homes for the aged can be an asset to a neighborhood—not a detriment.

Transportation: Relatives and friends of patients should be able to reach the site easily.

Emergencies: Medical and other services not included in the home should be nearby.

Nuisances to be avoided: Noise, smoke, fumes, smells, children's playgrounds. Potential nuisances should also be considered.

Approaches: Grades should be minimal. The outward appearance should not be depressing. Creative architecture is necessary. Too homey or residential a look in a large building can often result in a dull institutional appearance.

Environs: Tall buildings, hills, and dense trees sometimes cause excessive shade and deflect prevailing summer breezes.

Topography: Gradual inclines or level ground should be selected to avoid steep walks, steps and ramps —the latter very dangerous if exposed to ice formation.

Views: Eye appealing, interesting views or busy streets that can be properly related to a plan are highly desirable. The aged often dislike looking out from their rooms onto quiet unused courts—across which are more aged looking back at them. Contact with a busy passing scene is considered so important, in fact, that at least one home for the aged has been designed where most residents will look out upon an expressway. The tendency of aged patients to sit at windows puts a premium on the orientation of the rooms. They should face south or southwest.

Entries: Entrance steps, heavy doors, and door closers should be avoided at entries. No thresholds or rugs should be used. A seat should be provided just inside or outside the front door where the aged can rest or wait for help if in difficulty.

Floor plan: The proneness of the elderly to fall indicates that all facilities should be on one level. Floors must be nonslip. Vinyl asbestos plastic tile will, with some manufacturers, have this feature plus good resiliency. Floors should not be highly reflective and should be able to be maintained with nonskid waxes.

Lighting: The aged need from two to three times as much light as a 20-year-old in order to see as well. Windows should be exaggerated, therefore. Increased size also decreases glare. Large windows, however necessitate roof overhangs to reduce excessive sun, especially on the south. Cross ventilation is necessary for thorough airing when necessary. Vented sections of the windows—preferably of the hopper, no-draft type—should be effortless to operate.

Noise: The aged are particularly unable to adjust to excessive and unexpected noises that surprise and shock. Sites and building locations should be chosen where a reasonable over-all intensity of sound is not exceeded. Forty decibels is maximum. Walls between rooms should reduce airborne sounds to 40 decibels.

Hardware: Hardware throughout should be easily grasped or pulled. The feebleness of the elderly makes this imperative.

Special facilities: Night lights and call bells are necessary. Luminous switches should be used. The path between bath and bed should be well lighted and as unobstructed as possible. This path is the area of greatest number of accidents and grab bars should be installed along corridors. A 9-inch grab bar should be located in each water closet to the right, if possible. As a group, elderly people are shorter than the average population and thus the lavatory should not be over 31 inches high. Other dimensions are in proportion.

Heat: More heat is required for the aged than for younger people. Temperatures needed are, on an average, five degrees higher than normal. Special study must be given to radiant loss from walls and large glass areas. Although the aged suffer particularly from chilly hands and feet, radiant heating in the floor should not be used. Experience indicates that such heating aggravates problems arising from the elderly's often impaired circulation. In many modern nursing homes, each building is not only air conditioned but there are individual room controls for both heating and cooling. The decision to provide such an expensive mechanical system is based on administrators' and architects' experience that in the care of old people, temperature control could provide more trouble or pleasure than any other factor. ■

Charles Haeuser, A.I.A., is with the firm of Charles Haeuser Architects, Milwaukee, Wis. This material is adapted from a speech presented at the Tri-State Hospital Conference, Chicago, April 1958.

ASSOCIATION SECTION

The following action was taken by the AHA Board of Trustees at its meetings in Chicago Aug. 16-20, 1958. Further actions of the Board will be reported in subsequent issues of this Journal.

VOTED: To adopt, subject to concurrence by the Council on Professional Practice, the Statement on the Joint Conference Committee recommended for adoption by the Joint Committee of Trustees of the American Hospital Association and the American Medical Association.

The American Hospital Association Council on Professional Practice has now voted to accept this statement.

STATEMENT ON THE JOINT CONFERENCE COMMITTEE

PREAMBLE

As the art and science of medicine have become more complex and more comprehensive, hospital services, of necessity, have followed suit in an effort to produce maximum results from medical progress. For this reason and because of the other joint and separate responsibilities which physicians and hospitals have in providing medical care and hospital services, organization and cooperation are essential.

These responsibilities cannot be discharged with maximum effectiveness without proper liaison between doctor and hospital, the doctor being represented in an organized manner by a medical staff and the hospital by its governing body and that body's designated representative, the administrator.

In addition to, but not in conflict with regularly established lines of authority and responsibility, there should be a common ground where these two groups can meet in order that there may be mutual understanding of each other's activities and problems. A suitable medium for this interchange of information and discussion is the Joint Conference Committee.

This document seeks to encourage the development and to strengthen the role of the Joint Conference Committee of the Board of Trustees and medical staff. It urges the establishment of such Joint Conference Committees because it believes that they will bring to bear on major decisions which must be made in the hospital a full measure of broad experience, intelligence and responsibility.

Such a committee should be a part of the organizational structure of every hospital. It should exist even where there is medical staff representation on the governing board. The representatives of this committee meet—not as representatives of the departments from which they were chosen—but as members of the committee as a whole in the interest of the patient, the physician, the hospital, and the community.

THE JOINT CONFERENCE COMMITTEE

The Joint Conference Committee is a discussion committee of the governing board and the medical staff. It has no intrinsic authority; if allowed to become an action group, its usefulness will at once be jeopardized.

PURPOSES

Its purposes, all directed toward better patient care, should be at least three:

a) Communications to keep board, staff and administration cognizant of pertinent actions taken or contemplated by one or the other. These should be reported to the committee even though they do not require action by more than one component of it. Open communications through the Joint Conference Committee will emphasize the importance of prior knowledge of all affected groups before action is instituted and will thus prevent misunderstanding.

b) Planning. Plans for growth and inevitable change in the hospital organization should be considered by this committee.

c) Problems. Issues which arise in the operation and affairs of the hospital affecting all parties should be brought to the committee for consideration.

ORGANIZATIONS

While the Joint Conference Committee may be organized in any of several ways the following, which is only a guide, is offered as an example:

a) The Joint Conference Committee of the governing board and the medical staff should be composed of equal numbers of representatives elected or appointed by the governing board and the medical staff. The administrator should be an ex officio member of the committee.

b) The chairman of the Joint Conference Committee may be alternated between representatives of the governing board and of the staff.

c) The Joint Conference Committee should meet at regular intervals no less frequently than four times per year, and should meet on call when necessary.

d) The committee should feel free to invite to its meetings persons within or without the hospital who can contribute from their specialized knowledge or experience.

e) A formal agenda should be prepared from suggestions of the members and submitted to all members of the committee in sufficient time before the meeting.

f) Minutes should be kept by the secretary and should be maintained in the permanent records of the hospital.

g) A resume of the minutes of the Joint Conference Committee should be presented at meetings of the governing board and at meetings of the medical staff.

NEW ADDRESS

The official address of the new headquarters building will be 840 North Lake Shore Drive, Chicago 11, Illinois.

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your president reports

ONE OF THE items which I think will interest all of us is the recent action of the Board of Trustees authorizing a listing program for nursing homes and asking the Council on Professional Practice to work out the details with the Council on Medical Service of the American Medical Association. This is a very complex matter and it will require the most careful study and cooperation of all concerned to work out a satisfactory program that will provide the essential requirement for listing.

Liaison among the organizations that have to do principally with the patients and nursing homes is now at a stage of development where good progress should be made. One of the ongoing activities of the Association is the Joint Council to Improve the Health Care of the Aged. This council is composed of members of the American Dental Association, the American Hospital Association, the American Medical Association, and the American Nursing Home Association.

Just last week this council met and set up its constitution and bylaws for operation. Financing of its program has been arranged, and a full-time, capable secretary has been employed.

To get back to the listing of nursing homes, I am reminded that when licensure laws for nursing homes began to go into effect on a state-wide level, there was no way to ascertain how many facilities were being used for nursing homes. In our own state we assumed that there were quite a few, but the applications for licensure doubled the size of the estimate. An initial inspection of these institutions revealed that many of them were not true nursing homes in character.

The laws specifically provided that these institutions should be related to hospitals and should provide care in excess of board and room, and two major categories were therefore set up. Facilities providing board and room only were eliminated, and the problem centered around those that were true nursing homes. Some landmarks for the appraisal of a nursing home were set up, and a few of the procedures usually provided in general hospitals were used as a base from which to start, showing where hospital care ceased and nursing home care began, and where nursing home care ended and board and room became the prevailing type of care.

A START on the definition of a nursing home was then begun. The type of physical facility and staffing became a source of interest that still is not totally developed and requires a great deal more thought. The use of the title "nursing home" should surely mean that nursing is provided, and no true home of this character can be operated without the provision of essential nursing care.

The Minnesota law provides that there must be at least one graduate nurse on duty, and the provision of "around the clock" coverage under the supervision of the graduate nurse, through the use of other graduates or practical nurses, must be assured. When it comes to the listing of nursing homes, much has already been worked out through the application of Hill-Burton's token funds for construction. The amount of space required for each patient, the facilities for minimal nursing care, and the factors that have to do with safety also are pretty well established.

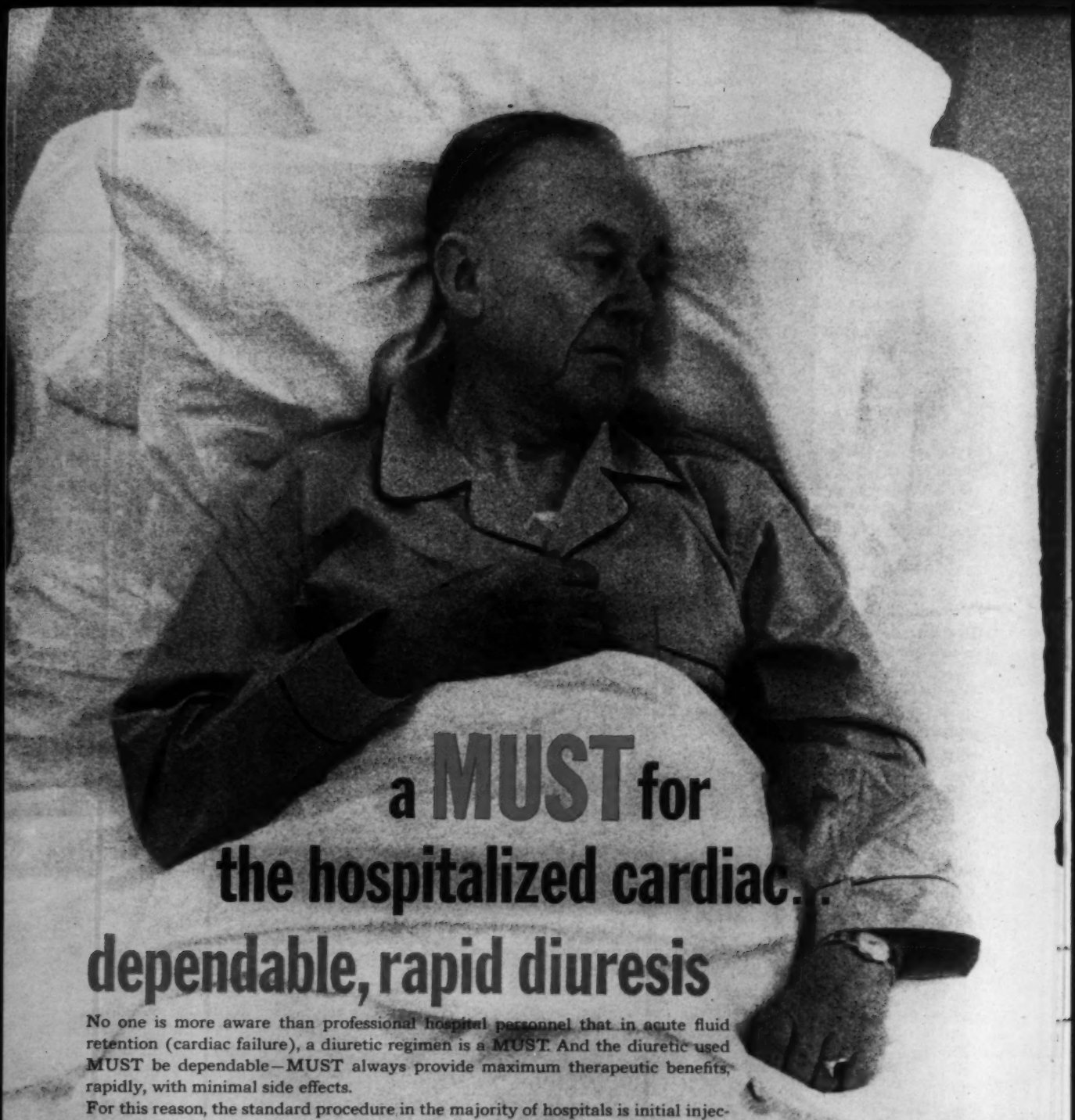
At the time this is being written, we are planning the dedication of a new nursing home for the University of Minnesota Hospitals with funds provided by the Masonic Fraternity of Minnesota, which will total more than a million dollars. More than fifty thousand members of the fraternity, and the women's groups allied with the Masonry, have made this institution possible through their gifts. The physical facilities have been designed in conformity with the best that we can find so far in this type of facility—adequate lounges, dining rooms, occupational therapy, nursing units, barber and beauty shops, patients laundries, offices for physicians, consultation and examining rooms, and many more assets for scientific, comfortable care.

We do not have this in mind as a terminal hospital but as a parahospital of hope and opportunity for recovery. In visiting many of the better nursing homes throughout the country—and some of them are every bit as good as our new facility—I was upset by the finality of the attitude expressed by some operators of these units. Many of them told me that at least 90 to 95 per cent of their patients were never discharged for any cause except that of death.

This leads me to believe that these institutions, if they are to stand side by side with the hospitals of the country, must make provisions for the type of care that will restore the patient to productivity and a useful, happy life if it is at all possible. Listing, I think, will go a long way towards help in this field.

Ray Amberg

Ray Amberg, president
American Hospital Association



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'SHORT-STAY' AND 'LONG-STAY'—

STUDY OF TWO RECOVERY ROOMS OFFERS CLUES TO INTENSIVE CARE UNIT DESIGN

(Continued from page 35)

ample, a pneumonectomy) and to most patients undergoing any procedure who are admitted to the unit outside of regularly scheduled operating hours.

A review of Table 1, at right, reveals differences in surgical load between the two study hospitals. More importantly, however, it indicates the fact that in Hospital B patients with certain diagnoses remain in the recovery room for periods of time considerably longer than would be necessary to react from anesthesia. This is particularly true for the last eight diagnostic categories.

The differences in the type of care given in the two units is also evident in comparing the average length of time each diagnostic category stayed in the two units. For example, in the postanesthesia recovery room, ovarian resection patients stayed an average of 3 hours and 40 minutes, while patients undergoing gastric resections stayed an average of 2 hours and 20 minutes. Patients with these same diagnoses stayed an average of 8 hours and 12 minutes and 16 hours and 36 minutes in the postoperative recovery room in Hospital B.

Table 1.—Average recovery room stays, listed according to classified procedures

SURGICAL PROCEDURE	NO. OF CASES Hospital		AVERAGE STAY IN RECOVERY ROOM Hospital	
	A	B	A	B
Hemorrhoidectomy	23	23	1:23	1:37
Breast biopsy	17	32	1:24	1:25
Dilation & curettage	92	45	1:27	1:48
Saphenous vein ligation	13	8	1:50	1:39
Cystoscopy	14	12	1:36	1:43
Pilonidal cystectomy	11	7	1:53	2:15
Inguinal herniorrhaphy	35	76	1:56	2:52
Myomectomy	6	—	1:35	—
Dental extraction	12	—	1:55	—
Fulguration of bladder	—	14	—	2:46
Thyroidectomy	8	22	2:26	3:16
Cardiac catherization	—	10	—	4:03
Transmetatarsal amp.	—	14	—	5:06
Mastectomy	8	16	2:38	5:21
Mid-leg amputation	—	10	—	5:21
Open reduction of femur	—	12	—	5:28
Hysterectomy	31	27	2:35	5:56
Exploratory laparotomy	—	22	—	6:34
Cholecystectomy	29	31	2:43	6:49
Appendectomy	7	55	1:24	6:58
Abdominal herniorrhaphy	6	15	2:50	7:01
Laminectomy	19	19	1:48	7:11
Ovarian resection/removal	7	10	3:40	8:12
Transurethral resection	11	61	2:15	8:20
Colostomy	—	18	—	9:08
Prostatectomy	11	20	3:07	10:26
Cystotomy	—	11	—	11:38
Gastric resection	6	24	2:20	16:36
Craniotomy	—	27	—	17:07
Intestinal resection	6	27	2:35	18:58
Thoracoplasty	—	10	—	20:34
Thoracotomy	—	15	—	23:30
Mitral valvulotomy	—	14	—	39:12
Pneumonectomy	—	8	—	40:56
Pulmonary lobectomy	—	15	—	49:26
Unclassified procedures	128	270		
Total cases	500	1000		
Over-all average stay			1:58	8:21

EFFECT OF ADMITTANCE TIMES

The effect of the time the patients were admitted on the average length of stay was not so marked in Hospital A's postanesthesia recovery room, primarily due to the limitation in hours and days it was open. The effect of time of admission on Hospital B's postoperative recovery room stays is demonstrated in Table 2, page 52. A review of these average stays reveals that Hospital B is, by keeping most late admissions for longer periods of time, using its recovery

Table 2.—Average recovery room stay for certain diagnostic groups admitted before and after 2:30 p.m.—Hospital B

OPERATIVE PROCEDURE	NUMBER OF CASES ADMITTED		AVERAGE RECOVERY ROOM STAY ON PATIENTS ADMITTED	
	7 a.m.-2:30 p.m.	2:30 p.m.-7 p.m.	7 a.m.-2:30 p.m.	2:30 p.m.-7 a.m.
Hemorrhoidectomy	15	8	1:31	1:49
Breast biopsy	23	9	1:32	1:18
Dilation & curettage	33	8	1:31	3:07
Saphenous vein ligation	4	4	1:35	1:42
Cystoscopy	7	5	1:08	2:03
Pilonidal cystectomy	5	2	2:11	2:25
Inguinal herniorrhaphy	50	26	2:12	4:09
Fulguration of bladder	4	10	1:45	3:21
Thyroidectomy	14	8	2:42	4:16
Transmetatarsal amputation	4	10	2:22	6:12
Mastectomy	10	6	2:54	9:25
Open reduction of femur	8	4	5:52	4.37
Hysterectomy	21	6	3:46	13:30
Exploratory laparotomy	13	9	5:13	8:35
Cholecystectomy	24	7	4:08	16:00
Appendectomy	6*	49	6:35*	7:01
Abdominal herniorrhaphy	12	3	6:55	7:25
Laminectomy	14	5	3:17	18:18
Ovarian resection/removal	5	5	5:45	10:39
Transurethral resection	29	32	4:12	12:04
Colostomy	6	12	5:30	10:54
Prostatectomy	9	11	4:17	14:55
Cystotomy				
Gastric resection	12	12	10:45	22:27
Craniotomy	12	15	18:55	15:40
Intestinal resection	18	9	18:53	14:08
Thoracoplasty	3	7	21:32	20:00
Thoracotomy	6	9	22:57	24:12
Mitral valvulotomy	10	4	35:05	48:16
Pneumonectomy	2	6	26:50	45:40
Pulmonary lobectomy	7	8	41:54	56:34

*This average influenced by one 80-year-old patient with a prolonged recovery room stay.

room to relieve the inpatient floors of heavy postoperative loads during evening and night shifts.

How many surgical patients did not receive the services of the postanesthesia recovery room in Hospital A because of the restricted operating hours? During the study period, when 500 cases were being accumulated, an additional 110 surgical procedures were performed on patients who would have been cared for in the recovery room if they had been operated on during the regularly scheduled operating room hours. In other words, 18 per cent of the patients operated upon were returned directly to their rooms.

At Hospital A, as in Hospital B, the patient floors during evenings and nights and on weekends are at their minimal staffing. It is safe to assume that many of these emergency patients required skilled postoperative recovery room care even more than did the patients operated on during scheduled hours. The inability to provide this type of care because of operating policies is a serious drawback of the short-stay, limited service concept.

HOW FUNCTION INFLUENCES DESIGN

Before any recovery unit is planned, the decision must be made as to whether postanesthesia care only, or postoperative care as well, will be given in this area. Design and policies are basically affected by this decision.

Most of the mechanical equipment required is the same for both units—oxygen, suction, and adequate lighting must be available to every bed. A review of the services required by the patients in both recovery units revealed differences in quantity rather than differences in the services themselves. Patients in both units required oxygen, suction, infusions, transfusions, and medications. The longer stay patients required them for longer lengths of time and, in the case of medications and transfusions, much more frequently.

The planning differences between the two units are, then, primarily matters of space requirement and layout. More generous utility room space, medication area, charting facilities, and larger refrigerators should be provided in the postoperative recovery room than would be required in a postanesthesia recovery unit. Facilities for diets must be considered if the patient is to remain in the recovery room for long periods of time. Other than these ancillary facilities, the bed space must be arranged so as to provide more privacy—at least between sexes. Fully reactive patients and visitors will be most uncomfortable if such considerations are not included in the design of the postoperative recovery unit.

Differences in administrative and medical policies and procedures should also reflect the difference in function of the two main categories of recovery rooms. The relationship between the surgical department and anesthesia department and the decision as to which of them is charged with the responsibility of supervising the patient's stay in the recovery room and of deciding upon his release from it will depend upon the type of recovery room service offered.

The nursing service, especially during evenings and nights, is vitally affected by these functional differences. It is obvious from the results of the study that the staff for a postoperative recovery unit must be planned for 24 hours a day, seven days a week, if the unit is to fulfill its maximum ob-

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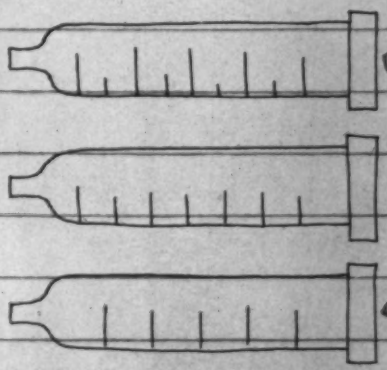

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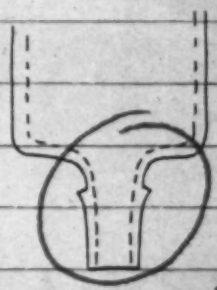

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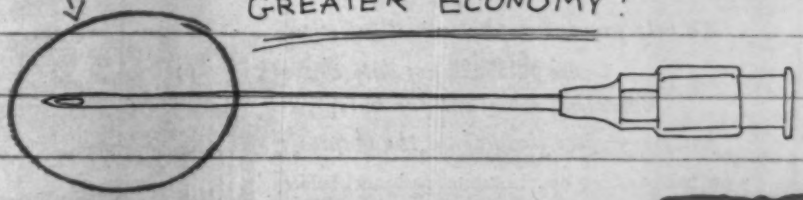

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To help prevent staphylococcal infection, use **pHisoHex** *not only in the operating room and the nursery— but everywhere throughout the hospital:*

- for handwashing by all hospital personnel before and after caring for every patient
- for routine washing of newborn infants
- to wash patients ante and post partum
- to wash patients who have a communicable disease
- to wash patients who have an infective disease of the skin
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TO REDUCE the spread of staphylococci and other organisms in hospitals, handwashing is "*... possibly the most important single control measure.*"[1] Just soap-and-water cleansing "... does not go far enough because it cannot be relied upon to kill the staphylococci."[2] But "when pHisoHex is used by nurses for handwashing, it is not possible to recover Staphylococcus pyogenes from their hands."[3] In addition, bacterial resistance to hexachlorophene does not develop.[4]

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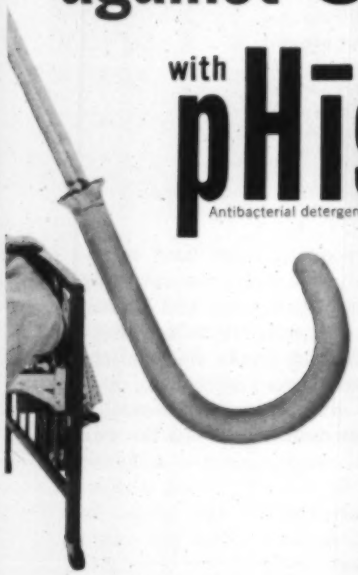

1. Brown, J. W.: *J.A.M.A.* 116:1185, March 8, 1958. 2. Klarmann, E. G.: *Am. J. Pharm.* 129:42, Feb., 1957. 3. Hardyment, A. F.: Pediatric Clinics of North America, Philadelphia, W. B. Saunders Co., May, 1958, p. 287. 4. Gould, B. S.; Frigerio, N. A., and Hovanesian, J.: *Antibiotics & Chemother.* 7:457, Sept., 1957. 5. Benson, M. E.: *Am. J. Nursing* 57:1136, Sept., 1957. 6. Wysham, D. N., et al.: *New England J. Med.* 257:295, Aug. 15, 1957. 7. Agate, G. H.: *J. Mich. M. Soc.* 57:853, June, 1958. 8. Medrek, T. F., and Litsky, W.: *Surg. Gynec. & Obst.* (Internat. Abstr. Surg.) 104:209, March, 1957.

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jectives. The effect of providing more comprehensive postsurgical care away from patient floors on the staffing of these floors must also be considered in making the decision as to the type of service which will be provided.

The surgical, anesthesia, nursing, and administrative staffs should consider the type of surgery the hospital is performing, or is planning to undertake, before deciding on a postoperative or postanesthesia recovery unit. Hospitals with large surgical subspeciality staffs —such as neurosurgery, thoracic surgery, or cardiac surgery—should consider the postoperative recovery room rather than the postanesthesia recovery room.

RATIO OF RECOVERY BEDS

The recovery room and the operating rooms should be planned as a single unit, not only because of the desired physical proximity of one to the other, but also because of their close functional relationship which makes them dependent upon each other.

The study discloses definite indications that the ratio of 1.25 beds* per operating room is not sufficiently large to care for peak loads occurring in either type of recovery room. A ratio of 1.75 to 2.0 recovery room beds would have been a more realistic figure in the two hospitals studied. This figure was reached by two methods: (1) an actual peak load count on a period of consecutive operating days (Tables 3 and 4, right,) and (2) an estimation based on the relationship between operating room time and recovery room time in Hospital A.

In spite of the fact that patients stayed in the postoperative recovery room four times as long on an average as did patients in the postanesthesia recovery room, the required recovery bed ratio per operating room, as tested by peak load counts, was about the same for both units. It was hypothesized that the difference in surgical load (relatively fewer short operations in Hospital B) and an operating schedule balanced between mornings and afternoons would result in two peak loads in Hospital B rather than one which would tend to minimize the number of patients in the recovery room at any one time.

This assumption is borne out by Figure 1, page 59, which is a composite picture of the time of day the 1500 study cases in the two units were actually in the recovery room. The postanesthesia recovery room reached its peak load at 1:30 p.m., while the postoperative recovery room had two peak loads, one at 1 p.m. and the other at 5 p.m.

The recovery room load is indissolubly bound to the operating schedule. Peculiarities and limitation of operating room schedules will result in peaks and valleys in recovery room utilization. Significant differences in operating room scheduling between the two hospitals resulted in the differing pattern of recovery room utilization illustrated by the graph. In Hospital A more (70.4 per cent) of the major surgery was scheduled before 1 p.m. In Hospital B a successful attempt was made to equal-

Table 3.—Hospital A—Recovery room activity during a 40-day study period

	PEAK LOAD	ADMISSIONS	OPERATING ROOMS
Maximum	12	22	
Minimum	4	6	
Average	7.6	15.0	6*

NUMBER OF DAYS THAT "N" BEDS WOULD HAVE SATISFIED PEAK LOAD REQUIREMENTS

Number of beds	Number of days	Percentage of days
12	40	100.0 per cent
11	38	95.0 per cent
10	37	92.5 per cent
9	33	82.5 per cent
8	27	67.5 per cent
7	17	42.5 per cent
6	11	27.5 per cent
5	7	11.5 per cent
4	2	5.0 per cent

*Includes one double cystoscopy unit

Table 4.—Hospital B—Recovery room activity during a 32-day study period

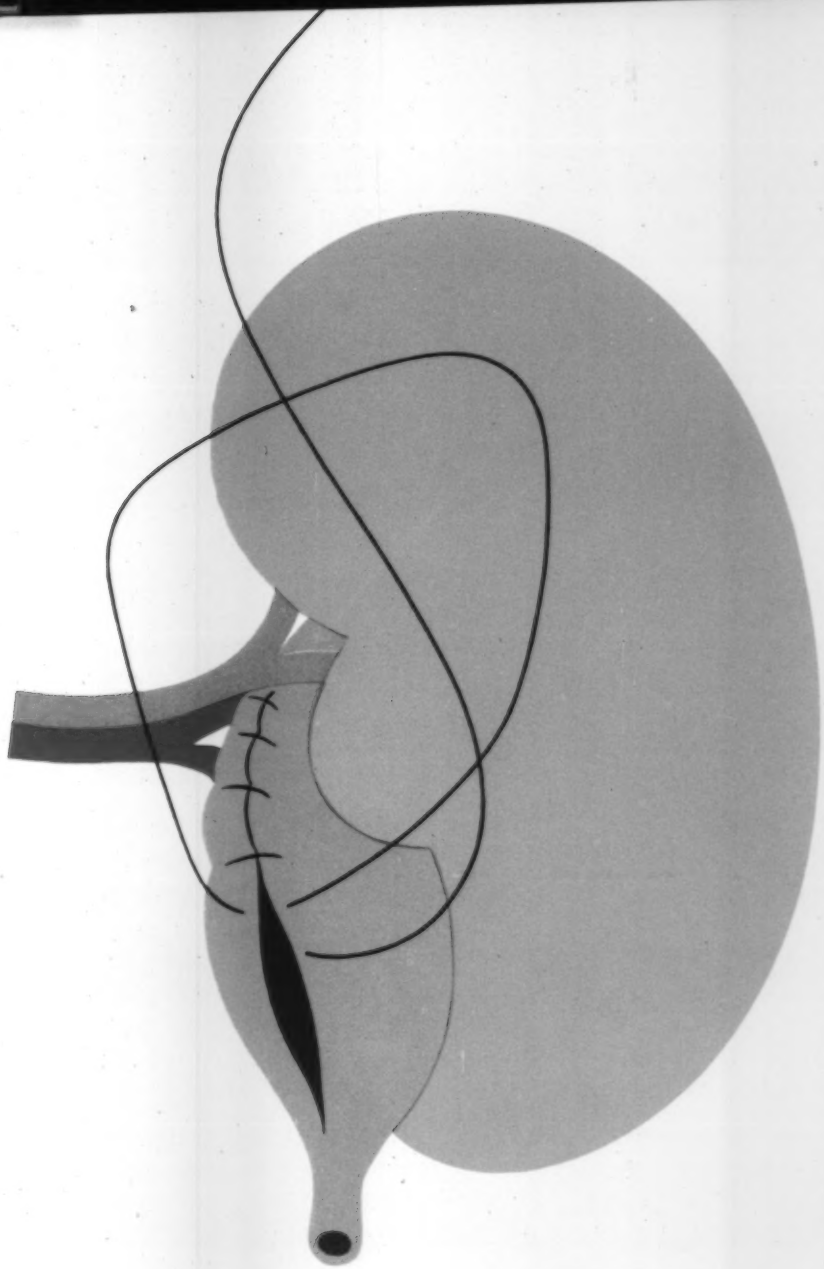
	PEAK LOAD	ADMISSIONS	PATIENTS TREATED	OPERATING ROOMS
Maximum	8	15	19	
Minimum	3	4	5	
Average	5.4	10.0	12.5	4*

NUMBER OF DAYS THAT "N" BEDS WOULD HAVE SATISFIED PEAK LOAD REQUIREMENTS

Beds	Days	Percentage of days
8	32	100.0 per cent
7	31	96.9 per cent
6	27	84.4 per cent
5	19	59.4 per cent
4	5	15.6 per cent
3	2	6.2 per cent

*Includes one double cystoscopy room

*Schafer, K. and Galbraith, T.P. Recovery room services—guide for planning. HOSPITALS, J.A.H.A. 26:65 Nov. 1952.



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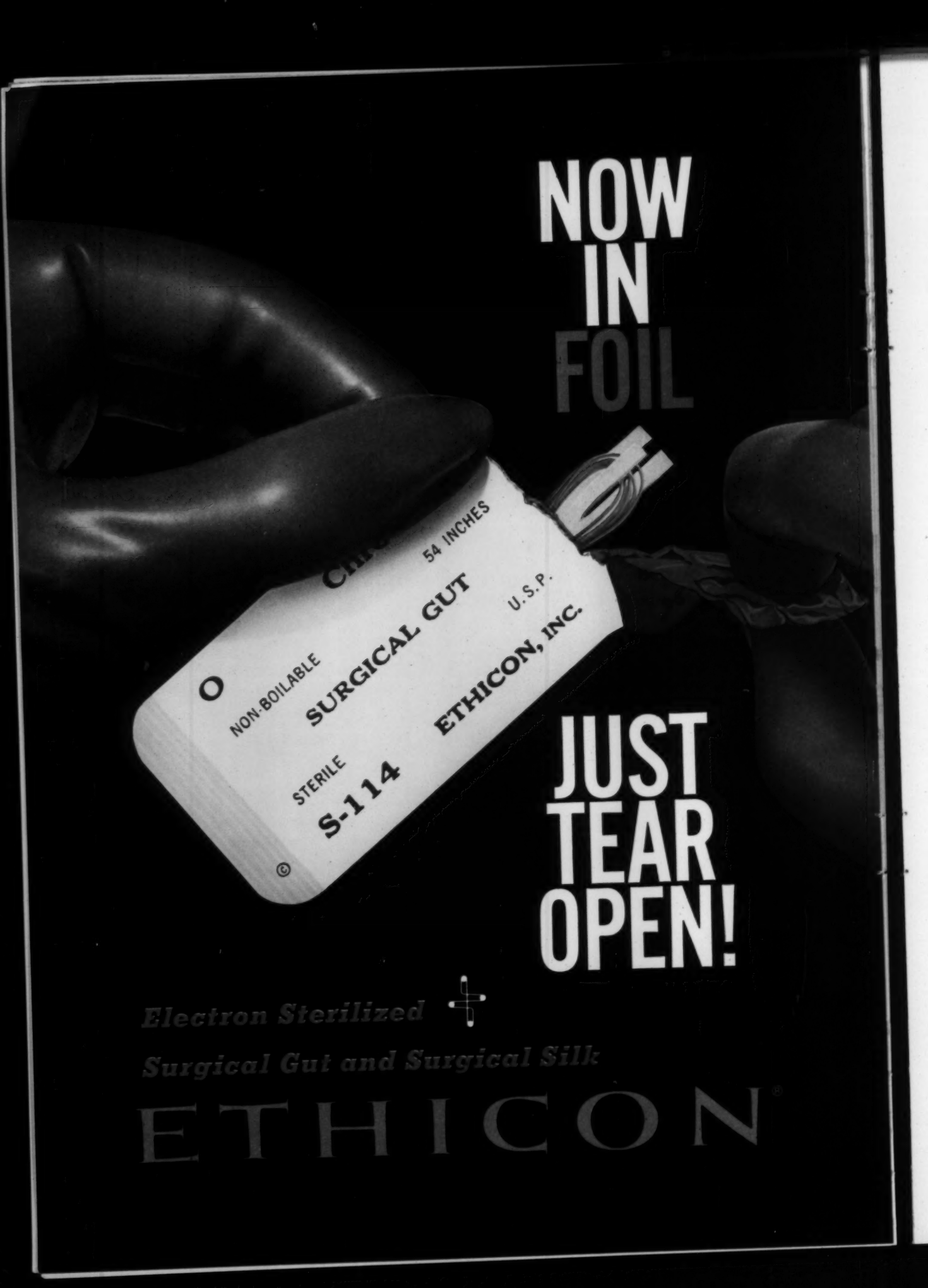
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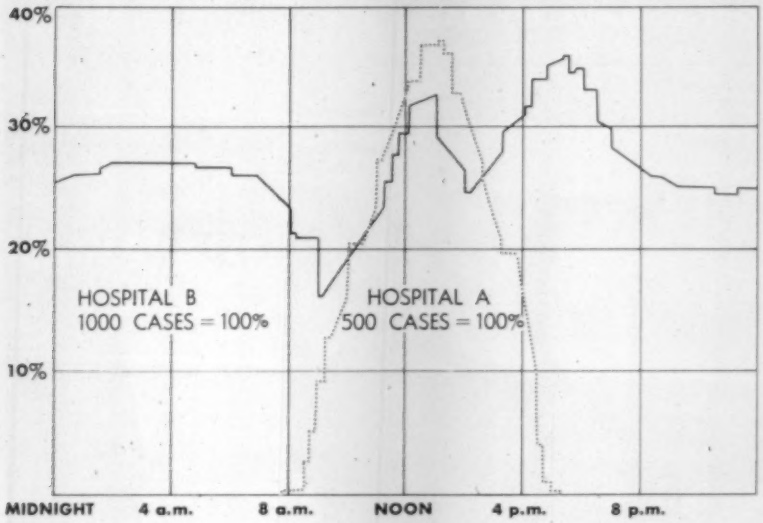
Fig. 1—Pattern of recovery room usage, showing number of patients in recovery room at any given time (Expressed in per cent of total cases)



ize major cases between the morning hours (51.6 per cent) and the afternoon hours (48.4 per cent).

The type of surgical load and the pattern of doing most of the surgery in the morning, as in Hospital A, is typical of many community hospitals and certainly must be considered when recovery facilities are planned.

POSSIBLE OPERATIONAL PATTERNS

An examination of the first seven diagnostic categories in Table 1 discloses a minimal difference in average recovery room stays in these categories between the two hospitals. If only hemorrhoidectomies, dilation and curettages, routine inguinal herniorrhaphies, pilonidal cystectomies, breast biopsies, cystoscopies, and saphenous vein ligations are considered, experience would seem to indicate that even when postoperative care facilities are available, they are not used for patients in these seven selected categories. By extension then, it may be presumed that the primary type of care needed by most of these patients is postanesthesia care and these patients would not usually require the services of an intensive care unit.

These operations comprise 40 per cent of the recovery room load in Hospital A (more typical in surgical load to the usual community hospital), but they account for only 20 per cent of the recovery room admissions in Hospital B. It is interesting to note that Hospital A independently arrived at this same list of surgical procedures for patients who would be eligible for a minimal care unit.

INTENSIVE CARE UNIT TRENDS

In programing an intensive care unit, the first decision is the relationship of that unit to the recovery room. Is the anesthesia recovery function to be carried out in the intensive care unit? In the few programs available for review, the trend seems to be separation of the postanesthesia area from the postoperative care area. Some findings of this study would support this policy. At least 40 per cent of the postoperative surgical patients would not need to be admitted to the intensive care unit, since they require only postanesthesia care.

The problem of treating patients immediately after surgery with medical patients on the same intensive care unit has been considered so formidable by some planners as to recommend this separation. Also, the location of a combined postanesthesia intensive care unit would present some planning problems, since it would have to be near the operating suite and convenient to the staff of the non-surgical specialities. In a hospital with a separated intensive care unit, the pattern of recovery room usage would then approximate that observed in Hospital A.

Such a separation would, however, dictate duplication of facilities, equipment, and staff. Consideration should be given to the inclusion of the anesthesia recovery room within the intensive care unit. If this were done, the pattern of postoperative stay would probably resemble that found in Hospital B. No predictions can be made on the basis of this study as to the pattern of medical or preoperative surgical stays which also would be included in most intensive care units. ■

NOTES AND COMMENT

Help for small hospital pharmacies

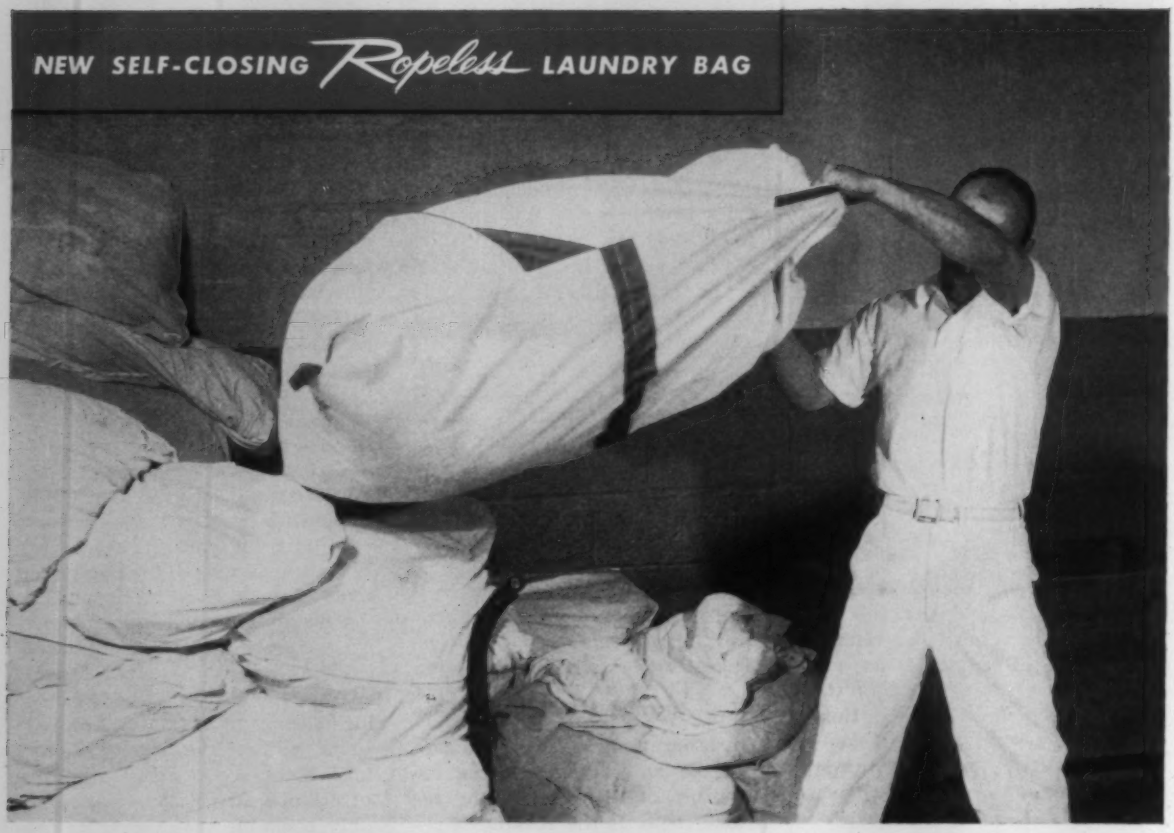
More than 4000 smaller hospitals throughout the country should enlist the help of local retail pharmacists to assist in providing medications for their patients, according to Assistant Prof. Alex Berman and John J. Zugich of the University of Michigan.

Mr. Zugich, formerly a hospital pharmacist and now an assistant director at the University of Michigan Medical Center, and Professor Berman, of the College of Pharmacy, have prepared a resource manual for administrators of smaller hospitals and community pharmacists.

The handbook offers an orientation to the pharmacy service problems facing community hospitals and outlines working relationships between smaller hospitals and retail pharmacists. The manual is

(Continued on page 112)

The Council on Professional Practice of the American Hospital Association has voted to accept the statement of the Joint Conference Committee recommended for adoption by the Joint Committee of Trustees of the American Hospital Association and the American Medical Association. Text of the statement appears on page 48 of this issue.



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How the pharmacist can help solve

PROBLEMS IN PURCHASING MEDICAL SUPPLIES

by MILTON W. SKOLAUT

There are numerous areas in which the purchasing agent and the pharmacist can work together to perform their functions more effectively and give greater service to patients, the author states. Writing of specifications for medical supplies and testing these supplies are two of the areas discussed by the author in which such collaboration pays valuable dividends.

THE PHARMACY DEPARTMENT at the Clinical Center, National Institutes of Health, is unusual in that the pharmacy and central sterile supply service are combined. We are involved in procuring and supplying practically all routine patient needs except laundry and food. In addition, such articles as eye glasses, elastic stockings, prosthetic appliances, and certain other materials fall within the scope of the operation. This situation has helped create a more than usual awareness of how the purchasing agent and pharmacist in a more typical hospital organization can by working together perform both jobs more effectively and in so doing give greater service to patients.

The pharmacist should be willing to consult with the purchasing agent in the establishment of specifications for drugs and supplies that come within his jurisdiction, and should work with the purchasing agent as closely as possible in order to provide the best product at the best price. A purchasing agent should be a person to whom the pharmacist can turn for help and vice versa.

In working to give the patient better service, the purchasing agent may find that a pharmacist can save him money by making up in the pharmacy such nonpharmaceutical items as laboratory stains and reagents, sodium-free baking powder, dietary supplements, room deodorants, stain removal solutions for the laundry, and water testing reagents for the engineering and laundry departments. If the purchasing department would like to procure and store such basic items as prescription containers, stable chemicals, petrolatum, soap, isopropyl alcohol, etc., few pharmacists would object.

DISAGREEMENT OVER FUNCTION

Frequently there is disagreement over the function of the purchasing agent in the institution. Too many purchases are made on the basis of friendship or the demand—without a sound basis—of professional personnel. We have known cases in which hospital personnel have demanded something regardless of price or quality. A purchasing agent must know that whatever he buys renders a satisfactory service to the persons who use it, and above all, contributes to the welfare of the patient. He can do his best by giving advice to the personnel with whom he deals and to anyone in the hospital who may need his services. A purchasing agent should not merely say, "This is how it is done". He should convince the persons interested in obtaining the products.

Frequently, professional personnel attend a convention or meeting where many hospital supply items are exhibited. Very often, they return from such an exhibit with only a portion of the information necessary to intelligently evaluate the item. Both the purchasing agent and the professional person have a responsibility to obtain this information and to standardize items in the hospital as far as possible, to serve the hospital in the best interests of the patient, and to do the job as economically as possible.

Pharmacists and purchasing agents in particular have a responsibility to all suppliers to keep them informed of possible future needs and trends so that they may in turn better serve the hospital.

The writing of proper specifica-

Milton W. Skolaut is chief of the pharmacy department, Clinical Center, National Institutes of Health, U.S. Department of Health, Education, and Welfare, Bethesda, Md. This article is based on a presentation at a meeting of the Purchasing Agents Section of the Maryland-District of Columbia-Delaware Hospital Association in November 1957.

tions is one of the most difficult tasks that anyone can assume. Probably the best plan is to start with an established set of specifications such as the federal government specifications and adapt them to the individual hospital needs. These specifications should include sufficient information for suppliers or bidders so that no doubt exists as to what is desired. They should also contain the methods the hospital plans to use in testing the materials to check their compliance with specifications. With this information, the supplier can pretest his products. When written or oral bids are obtained, samples should be requested, or if necessary, a small amount of the items should be purchased. Sample materials should be submitted to all possible tests, including actual use, to determine which ones meet or most closely approximate specifications. The purchaser should make sure that the supplier furnishes the identical material on the purchase order as he submitted as a sample.

Particularly in smaller hospitals, pharmacists can be very helpful to the purchasing agent and receiving personnel in the testing of many of these articles. One product which often causes problems is adhesive tape. All too often, rolls of adhesive tape with one or two yards of material still unused gather dust in the back of a drawer, and eventually are discarded because the tape is too hard to remove.

At the Clinical Center, since the pharmacists are in such close contact with the users of the tape, we are able to closely evaluate the problems connected with usage and storage. On a visit at an adhesive tape manufacturing plant, the author found that the winding machines are adjustable for changing tension in winding an adhesive tape roll. Thereafter, we wrote specifications stating that the pull required to remove the tape from the roll was to remain the same or become less as the core is approached. Our adhesive is now more completely used. A small pull tension scale is used to test the tension while the tape is unrolled at a fixed rate of speed. Storage of the adhesive tape under proper conditions is very important, since excess heat or freezing tends to destroy the adhesive properties.

A complex and controversial subject is sterile, disposable needles. Some claim that these needles are superior and less expensive; others say they are more expensive. Again, the best way to find out if they suit a hospital's particular needs economically is to establish minimum performance and purchase specifications, then purchase a quantity of needles and place them in general use. Comments from nurses and physicians concerning their ease in use and whether they are packaged satisfactorily will be valuable in helping to choose the right product for the hospital.

INTERCHANGEABLE SYRINGES

The same method can be used for testing interchangeable syringes and comparing them with the usual matched glass syringes. Generally, interchangeable syringes should be less expensive, but this is not always the case. Only a study will show whether both parts of the syringes are frequently broken, or if syringes are being pilfered from the hospital stock for illegitimate use. If only one part of the syringe needs to be replaced, then the interchangeable sets may prove more reasonable over a period of time. If chosen carefully as to quality, interchangeable syringes can be as satisfactory as the regular matched type. The one requirement for use of interchangeable syringes is that the hospital buy from the same supplier for a considerable length of time once the correct one has been procured.

SPECIFICATIONS FOR GAUZE

In many instances, a pharmacist in a smaller institution may help the purchasing agent establish proper specifications for gauze and cotton type dressings. A more expensive type of gauze may really be less expensive in the long run because it is more absorbent, thus requiring fewer dressings to be packaged and sterilized, and fewer dressing changes for the patient and professional staff. A simple absorbency test by weighing before and after wetting with distilled water will give surprising results as to the actual absorption.

Very expensive mistakes can be made by buying inexpensive instruments. The majority of sterile supply instruments are being imported, and many of these are of excellent quality. However, many are of very poor quality and are sold at reduced prices. These seemingly inexpensive instruments will not be in use very long before corrosion occurs or they become generally unfit for use. Cutting edges become dull and will need repair or will be discarded very quickly. Federal government specifications provide for instruments in a combination of composition G & K corrosion-resistant metals, and outline very simple tests for each. For example, a boil test with distilled water to determine proper composition can be performed in any pharmacy or laboratory. The pattern is important in surgical instruments, and this rather limits the number of suppliers of some types of devices. However, instruments for general hospital use can generally be purchased from many suppliers.

THERMOMETERS

Thermometers are among the most difficult items to purchase. One may obtain quotations on a wide variety of thermometers, from those for which accuracy and permanency of pigment are guaranteed to those that are sold on a price basis.

At the Clinical Center we have established specifications for thermometers and have developed a proper testing method; variations found are surprisingly large. Many thermometers tested varied as much as ½ to 1°C. from a standard testing thermometer. There have been occasions when medication has been needlessly started for a patient when an inaccurate thermometer showed a 1°C rise in temperature. Likewise, medication has been withdrawn too early from a patient whose temperature, according to a faulty thermometer, had lowered to normal.

Buying thermometers on a price basis without testing for accuracy can have serious results. Oftentimes a thermometer shows a temperature drop immediately upon being removed from a patient's mouth, making an accurate read-

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ing impossible to obtain. The pharmacy or clinical laboratory can purchase a standard thermometer and water bath and institute an accurate testing program without difficulty.

Because the iodine and isopropyl alcohol used in the newer technique in thermometer sterilization remove the markings on many thermometers—resulting in inaccurate readings and early discard—thermometers should be tested for permanency of pigment as well as accuracy.

There are not usually many problems between pharmacists and purchasing agents concerning specifications on drugs and chemicals. Many of the standards are set by the United States Pharmacopeia and the National Formulary. The pharmacist who furnishes drugs by these standards is fulfilling his responsibility and is obtaining a good product.

It is not economical to the hospital to continually change manufacturers or suppliers of certain products, particularly those that may be classed as long-term medications. For example, many problems ensue if such items as digitalis products and steroids of certain types are changed in color or shape without prior notification of all concerned. The nurse receiving the material on the unit will usually question this change and the patient will certainly question it, complaining that the product does not have the same effect as the previous one. Finally, the physician will question the pharmacist and may doubt the accuracy of the label, particularly if the patient has complained of not obtaining the identical results as with previous brands.

The same pattern is true with outpatients, and the hospital pharmacist is then usually required to stock several brands of the identical medication. The pharmacist must also label each product with a proper synonym, or trade name, if this is the labeling habit in the hospital, in order to avoid being accused of substitution.

Considering all of these facts, it is not always economical to change from one supplier of a drug to another simply to save a few cents on a pint of solution or a bottle of 1000 tablets.

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Sometimes deliveries can be scheduled even more frequently than monthly. At the Clinical Center, which is close to a supplier of intravenous solutions, a delivery of solutions is made each week. With this system, solutions are kept fresh by fast turnover and a minimum of storage space is used. ■

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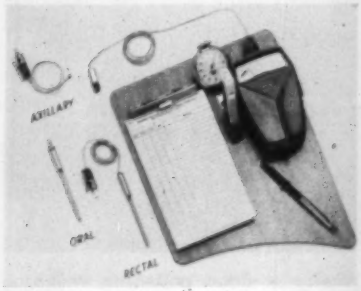
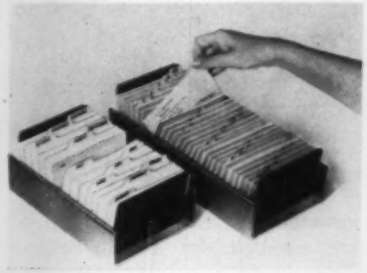


Plastic laminate-faced doors (21C-2)

Manufacturer's description: Silhouettes to designate certain special rooms in hospitals may be inlaid in this laminate-faced door in contrasting color at the time of its manufacture. These silhouettes are permanent and flush with the face of the door. The doors are available in a variety of standard colors and patterns and all doors have frames which accommodate closers and conventional butts and locks. Wood blocking is provided for all other hardware specified. Wear-resistant scuff plates are obtainable. The doors require little or no maintenance and can be kept clean with soap and water. *Bourne Mfg. Co., Dept. H, 1573 E. Larned St., Detroit 7, Mich.*

Card caddy (21C-3)

Manufacturer's description: Quicker, easier use of 3x5 card records is possible with this lightweight aluminum card caddy. It is available in lengths of 6, 9, 12, 18, and 24 in.

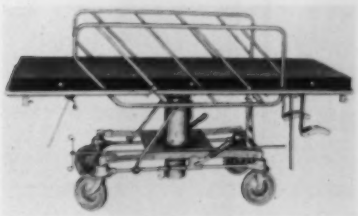


The caddy is adjustable for few or many cards and to "hold" place. It can be stored conveniently in a desk drawer. *The Hahn Co., Dept. H, Box 64532, Los Angeles 64, Calif.*

Wheeled hydraulic recovery stretcher (21C-4)

Manufacturer's description: An innovation of this wheeled hydraulic recovery stretcher is the inclusion of smooth sliding safety sides that will not bind. Other features are: 30-degree Trendelenberg, four-wheel brakes, height adjustment of 11 inches, hinged back rest section. Shoulder braces, head rest and I.V. rod, removable tray for plasma, glucose, etc., are optional equipment. *F. & F. Koenigkramer Co., Dept. H, 96 Caldwell Drive, Cincinnati 16, Ohio.*

New product descriptions included in this section are condensed from reports furnished by manufacturers and distributors. Descriptions are included here for informational purposes and such inclusion does not constitute endorsement by the American Hospital Association.



Cardiological x-ray unit (21C-5)

Manufacturer's description: Image amplification with new equipment and tube is accomplished in the same manner as in conventional fluoroscopic examination, but with several important advantages: it per-

▶ If you wish to have your name sent direct to the manufacturers of products and distributors of literature described in this review, check the appropriate items on this coupon, sign your name and address, clip and mail to the Editorial Department of HOSPITALS, J.A.H.A., 18 E. Division St., Chicago 10, Ill.

PRODUCT NEWS

- ____ TPR board (21C-1)
- ____ Plastic laminate-faced doors (21C-2)
- ____ Card caddy (21C-3)
- ____ Wheeled hydraulic recovery stretcher (21C-4)
- ____ Cardiological x-ray unit (21C-5)
- ____ Germ resistant blanket (21C-6)
- ____ Copying machine (21C-7)
- ____ Aluminum tub truck (21C-8)
- ____ Payroll tax computer (21C-9)
- ____ New wax-removing disc (21C-10)
- ____ Refuse disintegrator (21C-11)
- ____ Wedge-shaped telephone booths (21C-12)
- ____ Packaged hypodermic needles (21C-13)
- ____ Charge control device (21C-14)

PRODUCT LITERATURE

- ____ Concrete in hospital construction (21CL-1)
- ____ Injection system (21CL-2)
- ____ Medical inhalation therapy equipment (21CL-3)
- ____ Aluminum and steel grating (21CL-4)
- ____ Paint for galvanized surfaces (21CL-5)
- ____ Grease trap and plumbing treatment (21CL-6)
- ____ Ultrasonic cleaners (21CL-7)
- ____ Pneumatic tubes (21CL-8)
- ____ Casters, glides, and crutch tips (21CL-9)

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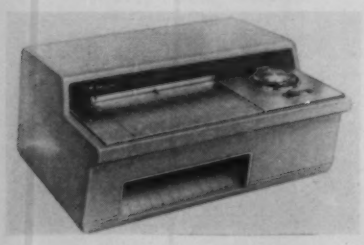
mits a substantial reduction in radiation exposure to the patient. A study of the heart by image amplification requires only 1/10 as much intensity as by fluoroscope. It provides an image 350 times brighter than by fluoroscope and allows an entire medical team to watch a TV screen simultaneously. It enables the diagnostician to avoid exposure completely by us-

ing a TV screen in another room. *Picker X-ray Corp., Dept. H, 25 S. Broadway, White Plains, N.Y.*

Germ resistant blanket (21C-6)
Manufacturer's description: Germ-resistant blanket is a 50 per cent wool-50 per cent cotton blanket in regular hospital size, 66 x 90, 2¾ lbs. in weight, and available in cedar, green or rose colors. The blankets are treated with germ-killing chemicals at the time of their manufacture. Laboratory tests have shown that the germ-resistant quality remains for the entire life of the blanket. Chemicals used to treat the blanket are nontoxic. *H. W. Baker Linen Co., Dept. H, 315 Church St., New York 13, N.Y.*

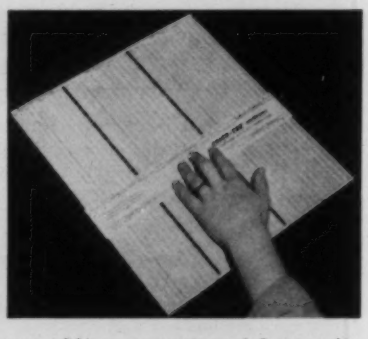
Copying machine (21C-7)
Manufacturer's description: Restyled copying machine, using heavy copy paper, makes completely dry copies of documents in less than four seconds. The machine is colored buff and blue with aluminum trim. The Type 30 copy paper is durable and stiff to resist tearing and rough handling. *Minnesota Mining and Mfg. Co., Dept. H, 900 Bush St., St. Paul 6, Minn.*



Aluminum tub truck (21C-8)
Manufacturer's description: This labor-saving truck is useful wherever

individual parts, pieces or parcels are handled. Its unique floating deck always keeps the load within easy reach of the operator, whether standing or sitting. Because its spring-loaded deck automatically brings the load within easy reach, the tub can be deeper and larger than a conventional tub and still be easy to maneuver. The casters feature sealed-in, permanently lubricated bearings that do not require any servicing. *M. Neushul Co., Inc., Dept. H, 1852 E. Pacific Coast Highway, Wilmington, Calif.*

Payroll tax computer (21C-9)
Manufacturer's description: Computer shows withholding tax and the



new 2½ per cent social security deductions all on one line for wage brackets up to $250. There are no pages to turn, no calculations to perform, and no special skill or practice is required to use it. A plastic slide is moved to the desired wage bracket and the figures copied. Replacements available as tax rates change. Price of the unit is $6.95. *Calcu-Tax Corp., 49 W. 37th St., New York 18, N.Y.*

New wax-removing disc (21C-10)
Manufacturer's description: Wax-removing disc is made of silicon carbide abrasive coated on a cloth backing. This open mesh cloth backing represents a new approach to the use of abrasives. The construction is specifically designed to prevent loading. When wax and dirt begin to accumulate, the disc can be rinsed clean in warm water. In this way, maximum life is obtained from the abrasive grains which do the work of removing the wax. For use, the 21-in. abrasive disc, No. 100, is placed on the floor, then a No. 2 steel wool pad, also 21 in. in diameter, is placed on top, and

finally a floor polishing machine equipped with a wire or fiber bristle brush is positioned over the two pads. *Behr-Manning Co., Division of Norton Co., Dept. H, Troy, N.Y.*

Refuse disintegrator (21C-11)
Manufacturer's description: New refuse disintegrator can consume 300 lbs. of garbage, paper or other refuse per hour, as well as reduce it to an odorless, insect and rodent-proof mass. The unit reduces volume of the material by as much as 80 per cent. In addition, the end product can be used as an organic soil conditioner. Stainless steel construction practically eliminates exterior maintenance on the machine. A feature of the disposal method is that it does not discharge pulp down the drain. The unit weighs about 550 lbs. and is powered by a three-horsepower

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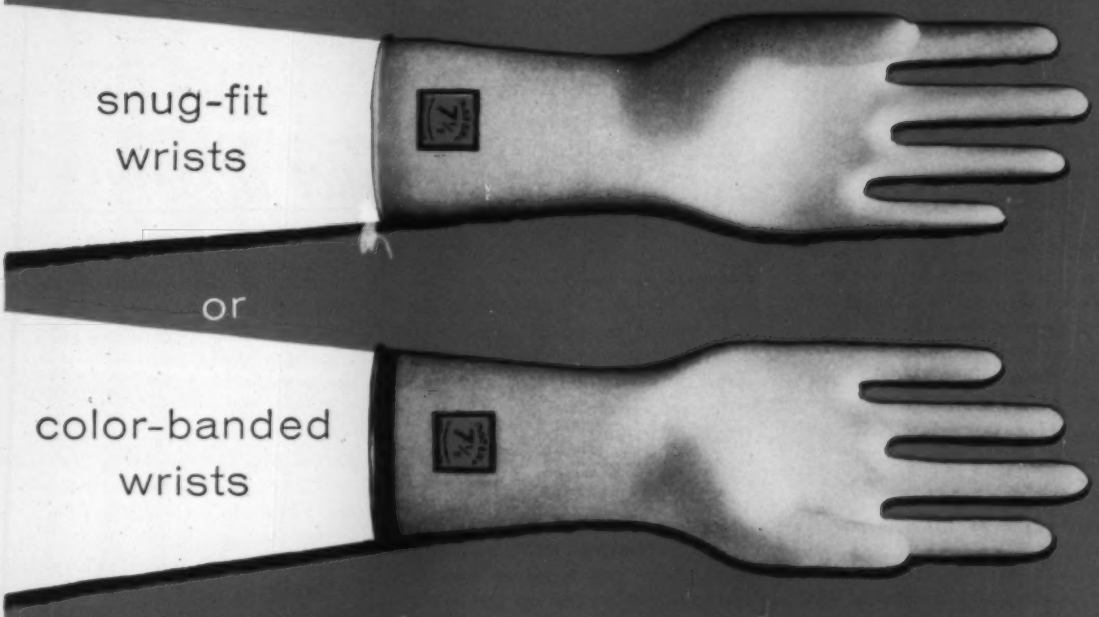

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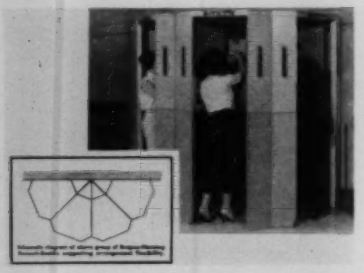
motor. *Meili and Worthington, Inc., Dept. H, Hatboro, Pa.*

Wedge-shaped telephone booths (21C-12)

Manufacturer's description: These wedge-shaped booths lend themselves to compact "half-circle" installations.



Walls of the booth are made of materials designed to absorb extraneous noise and to provide a quiet area without the usual disadvantages of a closed booth. There is no accumulation of dirt, no glass to break, and no foul odors. *Burgess-Manning Co., Architectural Products Division, Dept H, 5970 Northwest Highway, Chicago 31, Ill.*

Packaged hypodermic needles (21C-13)

Manufacturer's description: Needle package, consisting of a sheathlike container and heat-sealed cap, and the needle are gas-sterilized at the

factory after the cap is heat-sealed into place. Molded lugs on the inside of the container hold the needle in securely so that it does not touch the side walls. For easy identification, the individual containers are color-coded to gauge and also marked in black with length and gauge information. The container may be left on until the last moment, eliminating the need for wiping the needle with alcohol-soaked sponge or cotton to protect its sterility. *Roehr Products Co., Inc., Dept. H, Deland, Fla.*

Charge control device (21C-14)

Manufacturer's description: This device holds two pads of forms together in registration, one of which is movable in vertical direction on a metal slide. Each department has its own recorder and posts the patient's charges on the original charge control journal. A carbon copy is created simultaneously on the pad underneath the journal and this charge slip is simply pulled out from its perforation and forwarded to the accounting office. At the close of the day the charge

control journal sheet serves as a control check against possible missing charges. *The Shelby Salesbook Co., Dept. H, Shelby, Ohio.*

product literature

SEE COUPON, PAGE 65

Concrete in hospital construction (21CL-1)—A 32-page booklet giving typical examples and design details of the best application of structural and architectural concrete and concrete masonry in hospitals. *Portland Cement Association, Dept. H, 33 W. Grand Ave., Chicago 10, Ill.*

Injection system (21CL-2)—This 26-page booklet tells a picture story about two types of injection systems and points up the labor-saving and time-saving advantages of the closed system. *Wyeth Laboratories, Dept. H, 1401 Walnut St., Philadelphia 1, Pa.*

Medical inhalation therapy equipment (21CL-3)—Bulletin NM114 describes typical application of the intermittent vacuum regulator, Bulletin NM111 describes adult and infant aerosol tents, croup tents, and adult and infant face tents, and Bulletin NM113 shows various uses of the "Ventalung". *National Cylinder Gas Division of Chemetron Corp., Dept. H, 840 N. Michigan Ave., Chicago 11, Ill.*

Aluminum and steel grating (21CL-4)—Two bulletins are available, one giving engineering data and safe load tables for steel grating and steel stair treads, and the other giving information on aluminum grating and stair treads. *Kerrigan Iron Works, Inc., Dept. H, 274 Madison Ave., New York 16, N.Y.*

Paint for galvanized surfaces (21CL-5)—Technical Letter No. 13 describes a new paint formulation for the protection of galvanized surfaces regardless of their condition. *Lead Industries Association, Dept. H, 60 E. 42nd St., New York 17, N.Y.*

Grease trap and plumbing treatment (21CL-6)—A four-page brochure describes the uses and action of a material that digests grease and sludge and eliminates odors and stoppages in grease traps, kitchen drains, septic tanks, plumbing lines and cess pools. *Reliance Chemicals Corp., Dept. H, P.O. Box 19343, Houston 24, Tex.*

Ultrasonic cleaners (21CL-7)—Detailed descriptions of a complete line of ultrasonic cleaners is described in this four-page catalogue. *The Narda Ultrasonics Corp., Dept. H, 625 Main St., Westbury, L.I., N.Y.*

Pneumatic tubes (21CL-8)—A complete brochure contains photographs showing a pneumatic tube system in use throughout a hospital. Installation drawings are also used. *Lamson Corp., Dept. H, Syracuse 1, N.Y.*

Casters, glides, and crutch tips (21CL-9)—An eight-page catalogue (Form No. 73058) includes a handy selection guide, suggested application information, and specifications. All products are illustrated and described. *Faultless Caster Corp., Dept. H, Evansville 7, Ind.*

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SELECTIVE MENUS FOR THANKSGIVING DAY

TO PROVIDE hospitals with suggestions for making their Thanksgiving Day menus extra festive, the editors of **HOSPITALS**, J.A.H.A., are presenting in this issue a Thanksgiving Day selective menu for each region of the country. A separate holiday menu for the Midwest, South-Southwest, East and North-Northwest is included below.

These holiday menus have been prepared by the authors of the AHA fall cycle menus, to key in with the fall cycle menu series, since Thanksgiving Day occurs within the fall menu cycle (Sept. 1-Nov. 30). The fall cycle menus were published in the July 1, July 16, August 1 and August 16 issues of the Journal.

The Thanksgiving Day menus were prepared so that they could be easily inserted in the fall cycle menus. On Thanksgiving Day, hospitals are invited to use

THANKSGIVING DAY SELECTIVE MENU FOR THE MIDWEST, SOUTH-SOUTHWEST, EAST AND NORTH-NORTHWEST

	breakfast	noon	night
Midwest	Bananas **or** Chilled Orange Juice Oatmeal with Strawberry Preserves **or** Rice Flakes Canadian Bacon **or** Rolled Omelet Date Muffins	Consomme Roast Long Island Duckling with Chopped Apple Stuffing, Giblet Gravy (F) **or** Roast Tom Turkey (S) Baked Yams (F) **or** Snowflake Irish Potatoes Broccoli Spears—Mock Hollandaise Sauce (F) **or** Buttered Asparagus Tips (S) Chilled Bartlett Pear Halves—Fresh Cranberry Relish Filling on Endive **or** Celery Hearts and Ripe Olives Hot Fan Rolls Individual Orange Baked Alaska (S) **or** Pumpkin Tarts with Whipped Cream (F)	Chicken-Vegetable Soup Ham and Swiss Cheese Club Sandwich (F) **or** Broiled Chopped Tenderloin Patty on Toast Points (S) Baked Potato Puffs (FS) Orange Glazed Beets **or** Buttered Carrot Strips (FS) Lemon-Pineapple Mold on Watercress **or** Iceberg Wedge—1000 Island Dressing Harvest Fruit Cup (fresh grapefruit sections, orange sections, red apple wedges, Emperor grapes, pomegranate seed garnish) (F) **or** Vanilla Ice Cream—Vanilla Wafers (S)
South-Southwest	Orange Juice **or** Grapefruit Juice Grits **or** Puffed Wheat Cereal Scrambled Eggs (FS)—Grilled Sausage Pattie (F) Biscuits—Strawberry Preserves	Mulled Apple Cider Roast Young Tom Turkey (FS)—Savory Cornbread Dressing—Giblet Gravy (F) Snowflake Potatoes (FS) French Style Green Beans (FS) with Slivered Almonds (F) Fresh Cranberry-Orange Mold (F) Relishes (celery hearts, carrot curls, assorted olives) Fan Tan Rolls *Pumpkin Tart with Cheese Turkey Design Topping (F) **or** Baked Pear (S)	Cream of Corn Soup—Croutons Cold Plate (turkey sandwiches with lettuce and tomato, potato chips, spiced peach) **or** Grilled Minute Steaks (S) Duchess Potatoes (S) Buttered Green Beans **or** Buttered Spinach (FS) Pineapple Sherbet—Sugar Wafers (F) **or** Baked Custard (S)
East	Orange Juice **or** Grapefruit Half with Cherry (F) Wheat Farina **or** Cornflakes Scrambled Egg—Breakfast Link Sausage Blueberry Muffin **or** Toast	Oyster Bisque with Croutons Roast Turkey (FS) with Giblet Gravy and Sage Dressing (F) Candied Sweet Potato (FS) Mexican Corn (F) **or** Frenched Spinach (S) Celery Hearts, Ripe Olives, Cranberry Jelly **or** Garden Salad with French Dressing *Pumpkin Walnut Tart (F) **or** Baked Pumpkin Custard (S)	Vegetable Soup Creamed Chipped Beef on Toast (FS) **or** Wiener Schnitzel Chantilly Potato Baked Acorn Squash (FS) **or** Brussels Sprouts Sliced Tomato Salad (F) **or** Pear Half with Cottage Cheese on Lettuce Mince Pie (F) **or** Vanilla Ice Cream (S)
North-Northwest	Orange Slices **or** Applesauce Farina **or** Ready-to-Eat Oats Cereal Link Sausage and Scrambled Eggs Homemade Danish Rolls **or** Toast	Roast Turkey (FS) with Dressing—Giblet Gravy (F) **or** Minute Steak (S) Mashed Potatoes (FS) Creamed Peas (FS) **or** Green Beans Almondine Molded Cranberry Salad with Mayonnaise **or** *Harvest Fruit Bowl Mincemeat Deep Dish Pie (F) **or** Pumpkin Center Ice Cream Roll (S)	Consomme Baked Ham (F) **or** Broiled Veal Cutlet (S) Stuffed Baked Potato (FS) Buttered Asparagus (FS) **or** Glazed Carrots Pineapple with Cottage Cheese **or** Lettuce Wedge with 1000 Island Dressing Pumpkin Custard with Whipped Cream **or** Royal Anne Cherries (S)

(F)—Full Diet (S)—Soft Diet (FS)—Full and Soft Diet

Bread, butter and a choice of beverages are to be included with each meal.

*Recipe for this item is included immediately following the menus.

Midwest Thanksgiving Day menu was prepared by Rita Bedessem, chief dietitian, Mount Sinai Hospital, Milwaukee.
South-Southwest menu was prepared by Bernice Hopkins, director of dietetics, Vanderbilt University Hospital, Nashville, Tenn.
East menu was prepared by Janette C. Carlsen, dietitian-in-charge, Johns Hopkins Hospital, Baltimore.
North-Northwest menu was prepared by Arvilla E. Sutton, chief dietitian, Trinity Hospital, Minot, N. Dak.

the menus below in place of the menu from the AHA fall cycle menu series that they would have used on November 27.

In addition to substitution of the day's menu, dietitians are cautioned to check the appropriate weekly market order for perishables to delete the items for the November 27 scheduled menu and substitute the items needed to produce these suggested menus.

The Thanksgiving Day menus in most instances feature a choice of entree, vegetable, salad and dessert on the noon and night menus. Two cereals and two fruits have been offered on the breakfast menu.

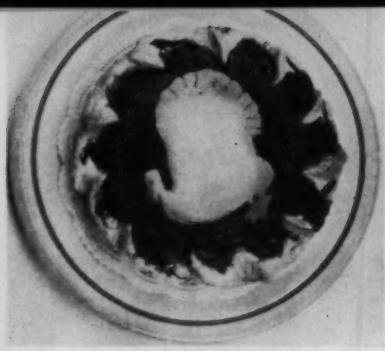
Since one of the choices offered on the Thanksgiving Day menus is designed for use on modified diets, the menus can be used for both normal and modified diets.

In addition to providing a selective menu for Thanksgiving Day, the authors have agreed to share their recipes for some of the Thanksgiving Day menu items.

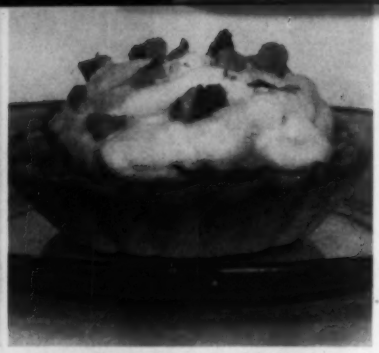
INDIVIDUAL ORANGE BAKED ALASKA

(One serving)

1. Flute orange and remove pulp.
2. Fill orange cup with orange sherbet and place in freezer for several hours.
3. At service time top each cup with meringue, using a pastry tube.
4. Brown in hot oven or under broiler until golden brown.



PUMPKIN TART



PUMPKIN WALNUT TART

PUMPKIN TARTS

1. Prepare pumpkin tarts according to your own favorite recipe.
2. At service time use cookie cutter to form turkey-shaped cheese topping for tarts.

PUMPKIN WALNUT TART

(50 servings)

11 oz. sugar
1½ qt. evaporated milk
11 oz. eggs
¾ oz. vanilla
40 oz. pumpkin
1 tbsp. cinnamon
1 tbsp. nutmeg
8 oz. chopped black walnuts
50 tart shells

1. Beat sugar, eggs, milk, pumpkin, spices and vanilla together.
2. Add two-thirds of chopped nuts to tart shells.
3. Pour custard mixture into tart shells.
4. Bake in 375°F. oven for 10 minutes or until set.
5. Top tarts with whip cream and remainder of chopped nuts.

HARVEST FRUIT BOWL

(25 servings)

25 oranges
25 modified maraschino cherries
6 bananas, diced
2 No. 2½ cans pineapple chunks
Celery leaves as needed

1. Scallop top of oranges and hollow out.
2. Dice orange meat and mix with pineapple chunks which have been drained. Add diced bananas and return to orange shells.
3. Top each orange shell with a whole maraschino cherry and celery leaves.

New York Hospital studies

NUTRITIONAL VALUE OF PATIENT SELECTED VERSUS NONSELECTED MENUS

by **LUCILLE WAKEFIELD** and **MARTHA POTGIETER, Ph.D.**

THE PROS AND CONS of selective menus is a familiar topic of conversation among dietitians today. Advocates of selective menus are praising the patient participation aspect afforded by this system and calling attention to the fact that selective menus can be just as economical as the nonselective menus used in many hospitals. Champions of the selective menu system also purport that there is less plate waste and more economical purchasing.

One aspect of the selective menu versus the nonselective menu system, however, has been treated rather lightly in the literature. This is the nutritional adequacy of the diets the patient selects for himself versus the ones the dietitian selects for him. In a recent study of 124 patients at Auburn (N.Y.) Memorial Hospital, it was found that patients who selected their diets from the regular hospital menu were receiving slightly poorer diets than a similar group of patients for whom diets were selected by a dietitian from the same menus.

Among the men patients, the diets of those who selected their menus were significantly lower in

Lucille Wakefield is associate professor of institutional management at the University of Vermont, Burlington, and Martha Potgeiter, Ph.D., is associate professor of foods and nutrition at the University of Connecticut, Storrs. The authors wish to express appreciation to Mary L. Greenwood, Ph.D., associate professor of foods and nutrition, University of Connecticut, for assistance with the statistical work. This article is based on a master's thesis submitted by Miss Wakefield in partial fulfillment of the requirements for the degree of master of science, University of Connecticut.

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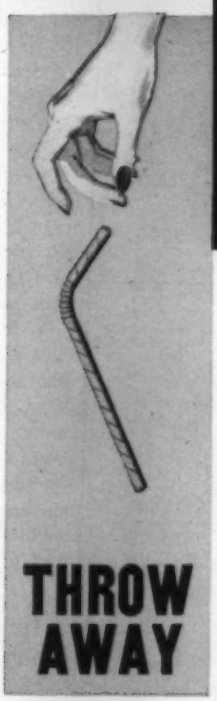

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iron than the diets selected by the dietitian. Among the women patients, those who selected their own diets had significantly lower intakes of protein, calcium, and riboflavin than those for whom the dietitian selected the menu.

For this study the dietary intake of 124 ambulatory patients, 40 to 50 years of age, on the regular house diet at Auburn (N.Y.) Memorial Hospital, was measured. Food intake for single days, scattered over a period of two months, was recorded for each of the 31 men and 31 women who had selected their meals from the regular house menu. On the same days the same number of patients were served meals chosen for them from the same menus by a dietitian. The day's food intake of each of these patients was also recorded. Carefully planned procedures were followed to assure correct weights and records and an unbiased sampling of data.[1]

Total intake of nutrients, excepting calories, was calculated for each patient for the single day, using the food composition data in Agriculture Handbook No. 8.[2] The diets were evaluated as to adequacy by comparison with the recommended dietary allowances of nutrients of the National Research Council Food and Nutrition Board for 45-year-old men and women.[3]

In general, the diets of the 124 patients were adequate, or very nearly so, in all nutrients, whether self-selected or not self-selected. However, there were a few exceptions. The intake of calcium by both the men and the women, on the average, was slightly below the recommended allowance of .8 gm. per day. The average intakes of thiamine and niacin by the men were below the recommended intakes. The nutrient most generously provided in all the diets was ascorbic acid. In each of the four groups of patients, for each nutrient, there were some individuals with a very low intake.

Male and the female patients eating the self-selected menus had a slightly lower intake of nutrients, in general, than those on the nonself-selected menus (see chart at left). One notable exception was the intake of ascorbic acid, which was slightly higher in the self-selected diets. The diets of both groups of patients were adequate, on the average, in this nutrient.

The only significant difference in intake, between the two groups of male subjects, was in the case of iron. The iron content of the self-selected diets was significantly lower than that of the nonself-selected diets. In other nutrients the diets of the two groups of men were similar. In all nutrients except protein (for the men) and ascorbic acid (for both the men and the women), the self-selected diets showed slightly lower values.

Women on self-selected menus had a significantly lower intake of protein, calcium, and riboflavin than those on the nonself-selected menus (See chart at left). The level of intake of other nutrients by the two groups of women was similar. In all nutrients, except ascorbic acid, the self-selecting group had a lower intake.

Average Daily Intake of Nutrients by Male and Female Patients on Self-selected and Nonself-selected Diets at Auburn (N.Y.) Memorial Hospital and the Recommended Daily Dietary Allowances

NUTRIENTS	SUBJECTS	TYPE OF DIET	AVERAGE LEVEL OF INTAKE	RECOMMENDED DAILY ALLOWANCES*
Protein—gm.	Male	Self-selected	72.6	65
		Nonself-selected	69.8	
	Female	Self-selected	64.0	55
		Nonself-selected	74.1	
Calcium—gm.	Male	Self-selected	0.727	0.8
		Nonself-selected	0.788	
	Female	Self-selected	0.708	0.8
		Nonself-selected	0.862	
Iron—mg.	Male	Self-selected	13.14	12
		Nonself-selected	16.31	
	Female	Self-selected	13.45	12
		Nonself-selected	15.31	
Vitamin A—I.U.	Male	Self-selected	5790	5000
		Nonself-selected	6920	
	Female	Self-selected	5920	5000
		Nonself-selected	6820	
Thiamine—mg.	Male	Self-selected	1.129	1.5
		Nonself-selected	1.219	
	Female	Self-selected	1.042	1.1
		Nonself-selected	1.180	
Riboflavin—mg.	Male	Self-selected	1.587	1.6
		Nonself-selected	1.597	
	Female	Self-selected	1.479	1.4
		Nonself-selected	1.801	
Niacin—mg.	Male	Self-selected	11.77	15
		Nonself-selected	12.39	
	Female	Self-selected	10.61	11
		Nonself-selected	12.42	
Ascorbic Acid—mg.	Male	Self-selected	91.0	75
		Nonself-selected	81.3	
	Female	Self-selected	93.5	70
		Nonself-selected	76.1	

*Food and Nutrition Board, *Recommended Dietary Allowances—Revised*, 1953. National Academy of Sciences-National Research Council Pub. 302, 1953.

APPLICATION OF FINDINGS

The patients who selected their menus had, in general, lower intakes of nutrients than did those whose menus were selected for them. These findings reflect a need for more nutrition education for patients and their families. While

it is recognized that prescribed vitamin and mineral supplements may compensate for a suboptimal level in the daily diet while patients are in the hospital, this supplementation will not be continued indefinitely. Nutrition education received in the hospital must be so effective that patients will know what to eat and will want to eat what is best for their health.

As a result of these findings, the regular hospital diet at Auburn Memorial Hospital has been enriched in vitamins of the B complex and in calcium, by the addition of wheat germ to meat loaf, gravy, and muffins and by the addition of powdered skim milk to mashed potatoes, cream soups, and white sauce. ■

REFERENCES

1. Wakefield, L. A study of the Relative Adequacy of the Self-selected and Non-self-selected Regular Diets of Ambulatory Patients at the Auburn (N.Y.) Memorial Hospital. Master's Thesis. University of Connecticut, Storrs, 1956.
2. Watt, B. K., and Merrill, A. L. *Composition of Foods—Raw, Processed, Prepared.* U.S.D.A. Agriculture Handbook No. 8, 1950.
3. Food and Nutrition Board. *Recommended Dietary Allowances, Revised 1953.* National Academy of Sciences—National Research Council Pub. 302, 1953.
4. Snedecor, G. W. *Statistical Methods* Ames, Iowa: The Iowa State College Press, 1946.

NOTES AND COMMENT

Need seen for dietetic frozen vegetables

On pages 64 and 65 of the August 16 issue of this Journal, it was announced that single portion packs of frozen vegetables have been introduced to the institutional market. Five varieties available for distribution are green peas, cut corn, baby lima beans, cut green beans and mixed vegetables. Each packet holds 2½ ounces of the vegetable.

Since the announcement, Richard M. Cooley, president of East Coast Marketers, Inc., Salisbury, Md. (one of the three companies responsible for the development of the packet process), reports that the company has received many requests asking if these vegetables could be packed without butter and seasoning, for service to patients on modified diets.

Mr. Cooley reports it is possible to pack the vegetables without butter and seasoning but it requires special handling throughout the entire production process. He said the minimum quantity that would be practical to produce would be 500 cases of each vegetable. Each case contains one gross of single portion bags.

Hospitals wishing to express their views on the pros and cons of special dietetic packs of vegetables may address their remarks to the East Coast Marketers, Inc., P.O. Box 138, Salisbury, Md. ■

Lazy Dazy cake featured on East winter menus

Lazy Dazy cake is one of the most popular dessert items with patients at Newton-Wellesley Hospital, reports Marie L. Casteen, director of dietetics at the Newton Lower Falls, Mass., hospital.

Through the courtesy of Miss Casteen, the recipe for this menu item is included here as well as

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DRINK
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LAZY DAZY CAKE

featured on the first week's menus, page 77.

LAZY DAZY CAKE
(96 servings)

1 lb. margarine
2 lbs. granulated sugar
1⅓ pt. (13-14) eggs, fresh or frozen
2½ tbsp. vanilla
2½ lbs. cake flour
1 oz. baking powder
1 tsp. salt
1⅓ pt. milk, approximately

1. Cream margarine and sugar together. Add beaten eggs, continue creaming until mixture is light and fluffy. Add vanilla.

2. Weigh and sift together the cake flour, baking powder and salt. Add slowly to egg mixture, alternating with milk.

3. Pour batter into greased baking pan (18" by 28"). Bake in 360°F. oven for 25 to 30 minutes.

4. Remove pan from oven and let stand for a few minutes before spreading on frosting (below).

FROSTING
(One 18" by 28" sheet cake)

12 oz. margarine or butter
12 oz. brown sugar, No. 10
1 c. 18 per cent coffee cream
10 oz. shredded coconut

1. Cream softened margarine or butter until light.

2. Add sifted brown sugar slowly, then the coffee cream and shredded coconut.

3. Spread frosting over top of baked sheet cake and bake until frosting is lightly browned. ■

Winter Cycle Menu for the East

THE 21-DAY selective winter cycle menu and market orders for perishables are designed for hospitals in the East. These menus, which are to be used during December, January and February feature foods popular in the eastern section of the United States.

The menus in this issue are the third in a four-part series of fall cycle menus published in this Journal. Winter cycle menus for the Midwest and South-Southwest were included in the October 1 and 16 issues of HOSPITALS, JOURNAL OF THE AMERICAN HOSPITAL ASSOCIATION. Winter menus for the North-Northwest will be published in the November 16 issue.

In planning the menus, careful consideration has been given to keeping the menu and food production operation simple for the smaller hospital. A moderate to low cost food budget was used.

This cycle menu features a choice of entree, vegetable, salad and dessert on the noon and night menus. Two cereals and two fruits are offered on the breakfast menu.

Since one of the choices offered is designed for use on modified diets, these menus can be used for both normal and modified diets. The letter (F) following certain items on the menu indicates that this item is to be served on the full or normal diets, while those labeled (S) are for the soft and other modified diets. Where the letters (FS) appear, the menu item is for the full and soft diets.

The fall cycle menus, for use during November, were published in the July and August issues of this Journal. The Midwest and South-Southwest cycle menus were included in the July 1 and 16 issues, respectively. The August 1 and 16 issues featured fall menus for the East and North-Northwest, respectively.

In adapting items marked (S) for use on modified diets, it should be noted that certain items will need sodium or fat restriction during preparation, if they are to be served on sodium restrictive or fat restrictive diets. When fruits are included on the dessert menu, the dietitian will omit sugar in preparation or substitute the water-packed variety for the diabetics.

The market order for perishables, which accompanies each week's menu, lists the meats, seafood, poultry, and fresh and frozen fruits and vegetables that a 50-bed hospital will need to produce the menu. The amounts are computed on the basis of serving 100 patient and personnel meals at breakfast, 125 at noon and 100 at night. By using a multiple of 50, larger hospitals can easily arrive at their market orders.

The market order includes all portion-ready meats, oven-ready roasts, portion-ready seafood, eviscerated poultry and other pre-prepared items.

An added feature of this menu service is the standard storeroom inventory, a list of supplies that a 50-bed hospital should have in the storeroom at the beginning of each 21-day cycle. The items included are cereals and farinaceous products, canned fish, canned fruits and fruit juices, dried fruits and vegetables, jellies, cake and pudding mixes, pickles, canned soups and canned vegetables.

1st WEEK EAST SELECTIVE WINTER CYCLE MENU

(MENUS TO BE USED DURING DECEMBER, JANUARY AND FEBRUARY)

—prepared by Marie L. Casteen, director of dietetics, Newton-Wellesley Hospital, Newton Lower Falls, Mass.

	breakfast	noon	night
monday	Orange Juice **or** Apple Juice Farina **or** Puffed Wheat Cereal Scrambled Egg—Bacon Graham Muffin	Vegetable Soup Grilled Sirloin Steak Patty (FS)—Pickle Relish (F) **or** Egg and Olive Salad Roll Baked Potato (FS) Buttered Beets (FS) **or** Creamed Shredded Cabbage Sliced Tomatoes on Lettuce **or** Jellied Lime and Orange Salad Butterscotch Brownies (F) **or** Royal Anne Cherries (S)	Bouillon with Crackers Baked Ham with Raisin Sauce (F) **or** Broiled Scrod Fillet (S) Browned Sweet Potato Slices (FS) Asparagus, Drawn Butter Sauce (FS) **or** Buttered Carrots Orange and Grapefruit Section Salad **or** Lettuce Hearts, Roquefort Cheese Dressing Apricot Pan Dowdy with Foamy Sauce (F) **or** Vanilla Ice Cream (S)
tuesday	Orange Juice **or** Stewed Prunes Wheat Farina **or** Corn Flakes Soft Cooked Egg Cranberry Muffin	Chicken Broth Broiled Chicken (S) **or** Seafood Newburg on Holland Rusk (F) Franconia Potatoes (FS) Buttered Wax Beans (FS) **or** Celery a la King Tossed Green Salad **or** Pear with Crushed Pineapple and Green Pepper Chips Chocolate Cream Pie (F) **or** Applesauce (S)	Half Grapefruit Roast Leg of Lamb (FS) **or** Grilled Tomato on Toast, Cheese Sauce Parslied Potato (FS) Buttered Peas (FS) **or** Whole Kernel Corn in Cream Peach and Cottage Cheese Salad **or** Sliced Beet and Egg Salad Floating Island (FS) **or** Strawberry Ice Cream
wednesday	Orange Juice **or** Grapefruit Juice Rolled Oats Cereal **or** Ready-to-Eat Wheat Flake Cereal Dropped Egg on Toast Whole Wheat Muffin	Beef Barley Soup Eggs a la Goldenrod on Toast **or** Roast Beef, Pan Gravy (FS) French Fried Potatoes (F) Stewed Tomatoes **or** Buttered Spinach (FS) Romaine with Orange and Grapefruit Sections **or** Carrot and Raisin Slaw Lazy Dazy Cake (F) **or** Fruit Cup (S)	Grape Juice Roast Turkey (FS)—Dressing and Giblet Gravy (F) **or** Scalloped Tuna, Noodles and Mushrooms Whipped Potato (FS) Buttered Green Beans **or** Baked Butternut Squash (FS) Macedoine of Vegetable Salad **or** Waldorf Salad Tapioca Cream Pudding (FS) **or** Nectarines in Syrup
thursday	Orange Juice **or** Apricot Nectar Farina **or** Ready-to-Eat Malt Flake Cereal Scrambled Eggs Rye Meal Muffin	Minestrone Soup Asparagus on Toast with Bacon **or** Oven Browned Chicken Leg (FS) Buttered Potatoes (FS) Peas (FS) **or** White Turnips, Supreme Chef's Salad with Shredded Cheddar Cheese **or** Winter Fruits Salad Gingerbread, Whipped Cream (F) **or** Sliced Bananas (S)	Tomato Juice Broiled Pork Chop, Apple Sauce (F) **or** Meat Loaf (S) Hashed Browned Potatoes (F) **or** Baked Potato (S) Buttered Beets (FS) **or** Broccoli, Mock Hollandaise Sauce Tossed Green Salad, 1000 Island Dressing **or** Cottage Cheese and Chive Salad Boston Cream Puff (FS) **or** Raspberry Sherbet
friday	Orange Juice **or** Grapefruit Half Wholewheat Cereal **or** Puffed Rice Cereal Dropped Egg on Toast Raisin Bran Muffin	Cream of Mushroom Soup Omelet, Sauce Mornay (FS) **or** Fresh Fruit Salad, Cottage Cheese, Pecan Bread and Butter Sandwiches Whipped Potato (FS) Buttered Carrots (FS) **or** Cauliflower, Browned Buttered Crumbs Jellied Cider Fruit Salad **or** Raw Vegetable Salad Cherry Pie (F) **or** Cabinet Pudding (S)	Fruit Punch with Sherbet Broiled Haddock, Lemon Butter (FS) **or** Baked Candied Sweet Potato and Apple, Bacon Curls Baked Potato (FS) Mashed Hubbard Squash (FS) **or** Fried Eggplant Salad Greens, Cucumber and Radish Slices **or** Sliced Orange and Watercress Salad Baked Indian Pudding (F) **or** Baked Pear (S)
saturday	Orange Juice **or** Sliced Bananas Rolled Wheat Cereal **or** Ready-to-Eat Cereal Griddle Cakes, Maple Syrup Cinnamon Rolls	Beef Barley Soup Toasted Cheese and Luncheon Loaf Sandwiches (F) **or** Roast Leg of Lamb (S) Creamed Potatoes (FS) Buttered Spinach (FS) **or** Braised Parsnips Pear Half with Sliced Olives on Lettuce **or** Chopped Escarole and Chicory, French Dressing Caravan Cake (F) **or** Elberta Dessert Cut Peaches (S)	Pineapple Juice Beef and Vegetable Pie (F) **or** Roast Leg of Veal, Brown Gravy (S) Paprika Buttered Potato (FS) Asparagus (FS) **or** Stewed Tomatoes Green Pepper Slaw **or** Tropical Fruit Salad, Shredded Coconut Applesauce **or** Country Club Ice Cream (FS)
sunday	Orange Juice **or** Pineapple and Orange Juice Farina **or** Corn Flakes Soft Cooked Egg Raisin Toast	Vegetable Soup Hot Beef Sandwich, Gravy (FS) **or** Fried Corn Meal Mush with Hot Spiced Apple Butter Baked Potato (FS) Buttered Julienne Green Peas (FS) **or** Savory Pearl Onions Combination Salad with Sliced Tomatoes **or** Avocado and Grapefruit Salad Toll House Cookies (FS) **or** Orange Sections	Prune Juice with Lemon Chicken Fricassee (FS) **or** Grilled Sliced Ham, Cranberry Relish Buttered Brown Rice (FS) Green Beans and Sauteed Mushrooms (FS) **or** Buttered Beets Jellied Perfection Salad **or** Celery Hearts, Stuffed Olives Strawberry Sundae (F) **or** Cup Custard (S)

(F)—Full Diet (S)—Soft Diet (FS)—Full and Soft Diet

Bread, butter and a choice of beverages are to be included with each meal.

PLEASE CUT ALONG THIS LINE

1st week market order for perishables (per 50 beds)

Item, Specifications, Amounts & No. of Servings			
BEEF			
Ground Beef	U. S. Good, 5 lb. pkg.	5 lbs.	
Roast, Sirloin (B.R.T.)	U. S. Choice	60 lbs.	
Sirloin, Chopped	U. S. Choice	20 lbs.	80
Stew	U. S. Good	15 lbs.	60
LAMB			
Leg (B.R.T.)	U. S. Choice, yearling	30 lbs.	
PORK			
Bacon (Sliced)	24-26-1 lb.	12 lbs.	
Chops, Loin	Grade A, 4 oz. each	15 lbs.	60
Ham (Pullman)	Ready-to-eat	30 lbs.	
VEAL			
Leg (B.R.T.)	U. S. Good	7 lbs.	21
FISH			
Haddock	Fillets, skinless, 4 oz. each	15 lbs.	60
Scrod	Fillet, 4 oz. each	5 lbs.	20
POULTRY			
Fowl (Eviscerated)	Grade A, 5 lb. av.	45 lbs.	
Legs, Chicken	Grade A, 5 oz. each	30 lbs.	90
Turkeys (Eviscerated)	Grade A, 20-24 lb. av.	45 lbs.	
Fryers (Eviscerated)	Grade A, 2½ lb. av.	12 lbs.	

Item, Specifications, Amounts & No. of Servings		
FRESH FRUITS		
Apples	Cortland, 125s	1 box
Avocado	Ripe	½ doz.
Bananas	Ripe	30 lbs.
Grapefruit	Seedless, 70s	1 box
Lemons		1 doz.
Oranges	176s	1 box
Pears	Box, 120s	20 lbs.
FRESH VEGETABLES		
Beets	Topped, bushel	50 lbs.
Cabbage	Bag	60 lbs.
Carrots	Topped, bag	50 lbs.
Celery	Pascal, 30s	6 stalks
Celery	White, Relish	6 stalks
Chicory	Heads	1 doz.
Cucumbers		½ doz.
Eggplant		2 only
Escarole	Heads	2 heads
Lettuce	Head, 48s	2 crates
Onions, Dry	Yellow, bag	50 lbs.
Onions, Green	Bunch	1 doz.
Onions, White	Boilers	3 lbs.
Parsley	Bunch	1 doz.
Parsnips		5 lbs.
Peppers, Green		1½ doz.

Item, Specifications, Amounts & No. of Servings		
Potatoes, Sweet	Hamper	50 lbs.
Potatoes, White	Bag No. 1	40 lbs.
Radishes	Bunch	1 doz.
Squash, Butternut		20 lbs.
Squash, Hubbard		25 lbs.
Tomatoes	Repacked (5 x 6)	1 lug (30 lbs.)
Turnips, White	Topped	5 bunches
FROZEN FRUITS		
Apricots	Halves, 8 lb. can, 5-1 sugar	16 lbs.
Cherries	Sugar, pitted, 8 lb. can	24 lbs.
Orange and Grapefruit Sections	Fresh, chilled, gallon	5 gal.
Orange Juice	Con., 32 oz. can	12 cans
Strawberries	Sliced, 8 lb. can, 5-1 sugar	8 lbs.
FROZEN VEGETABLES		
Asparagus	Spears, 2½ lb. pkg.	20 lbs. 120
Beans, Green	Cuts, 2½ lb. pkg.	12½ lbs. 75
Beans, Green	Julienne, 2½ lb. pkg.	15 lbs. 90
Beans, Wax	Cuts, 2½ lb. pkg.	15 lbs. 90
Broccoli	Stems and buds 2½ lb. pkg.	2½ lbs. 15
Cauliflower	Buds, 2½ lb. pkg.	2½ lbs. 15
Peas	2½ lb. pkg.	25 lbs. 150
Spinach	Chopped, 2½ lb. pkg.	30 lbs. 180

CYCLE MENU PAGES ARE PERFORATED FOR EASY REMOVAL

2nd WEEK EAST SELECTIVE WINTER CYCLE MENU

(MENUS TO BE USED DURING DECEMBER, JANUARY AND FEBRUARY)

—prepared by Marie L. Casteen, director of dietetics, Newton-Wellesley Hospital, Newton Lower Falls, Mass.

	breakfast	noon	night
monday	Orange Juice **or** Apple Juice Wheat Farina **or** Ready-to-Ea Rice Cereal Poached Egg on Toast Twin Mountain Muffin	Beef Broth Cheese Souffle **or** Sliced Turkey, Giblet Gravy (FS) Whipped Potato (FS) Spinach and Chopped Egg (FS) **or** Buttered Rutabaga Apricot and Pineapple Wedges on Lettuce **or** Tossed Crisp Greens, French Dressing Fudge Cake, Boiled Frosting (FS) **or** Pear Halves in Syrup	Consomme Italian Spaghetti, Meat Sauce (F) **or** Broiled Sirloin Steak (S) Parslied Potatoes (FS) Mashed Hubbard Squash (FS) **or** Buttered Mixed Vegetables Mexican Relish Salad **or** Banana, Peach and Ripe Olive Salad Fruited Gelatin, Custard Sauce (FS) **or** Maple Walnut Ice Cream
tuesday	Orange Juice **or** Tomato Juice Rolled Oats Cereal **or** Puffed Wheat Cereal Scrambled Egg Graham Muffin	Chicken-Rice Soup Grilled Ground Beef Patty (FS) **or** Baked Ham Roll with Dressing Au Gratin Potatoes (FS) Buttered Asparagus (FS) **or** Cauliflower Polonaise Stuffed Prune Salad **or** Lettuce Hearts, Russian Dressing Apple Pie (F) **or** Sliced Frozen Peaches (S)	Blended Vegetable Juice Casserole of Creamed Shrimps, Eggs and Peas (F) **or** Broiled Loin Lamb Chop (S) Baked Potatoes (FS) Buttered Julienne Carrots (FS) **or** Brussels Sprouts Jellied Sunset Salad **or** Cheese Balls in Mixed Salad Greens Vanilla Blancmange with Jelly (FS) **or** Fresh Fruit Cup
wednesday	Orange Juice **or** Blended Juice Whole Wheat Cereal **or** Bran Flake Cereal Soft Cooked Eggs—Bacon Oatmeal Muffin	Cream of Mushroom Soup Fluffy Omelet (FS) **or** Sautéd Chicken Livers Buttered Potatoes (FS) Harvard Beets (FS) **or** Succotash Fresh Fruit Salad **or** Celery Seed Cabbage Slaw Napoleon Slice (F) **or** Peeled Apricot Halves (S)	Cranberry Juice with Sherbet Roast Rib of Beef, Pan Gravy (FS) **or** Baked Stuffed Pork Chops Franconia Potatoes (FS) Buttered Green Peas (FS) **or** Fried Eggplant Chef's Salad **or** Cinnamon Apple Rings on Pineapple Snow Pudding, Custard Sauce (FS) **or** Frozen Fresh Raspberries
thursday	Orange Juice **or** Grapefruit Half Wholewheat Cereal **or** Ready-to-Eat Cereal Poached Egg on Toast Bill's Coffeecake	Vegetable Soup Manhattan Meat Roll, Gravy (F) **or** London Broil with Crisp Bacon (S) Grilled Tomato Halves French Fried Potatoes (F) Buttered Green Beans **or** Baked Butternut Squash (FS) Watercress and Lettuce **or** Orange-Date Salad Coconut Layer Cake (F) **or** Bing Cherries (S)	Beef-Barley Soup Braised Veal (F) **or** Sliced Turkey, Cranberry Sauce (S) Paprika Potatoes (FS) Chopped Spinach (FS) **or** Creamed Celery and Mushrooms Chinese Cabbage, Green Pepper Ring, Cottage Cheese and Mayonnaise **or** Cranberry Jewel Salad Frozen Fresh Peaches, Whipped Cream **or** Harlequin Ice Cream (FS)
friday	Orange Juice **or** Prune Juice Rolled Wheat Cereal **or** Corn Flakes Scrambled Egg—Bacon Grapenuts Muffin	Fish Chowder Baked Macaroni and Cheese (FS) **or** Grilled Lamb Patty Browned Sweet Potato (F) Stewed Tomatoes (F) **or** Buttered Kale, Crisp Chopped Bacon (S) Celery Sticks and Queen Olives **or** Combination Mixed Green Salad Cranberry Chiffon Pie (F) **or** Fruit Compote (S)	Grapefruit Half Broiled Blue Fish, Lemon Wedge (FS) **or** Baked Ham Mashed Potato (FS) Buttered Asparagus Spears (FS) **or** Creamed Onions Jellied Orange and Pear Salad **or** New England Vegetable Salad Cottage Pudding, Fruit Sauce (F) **or** Country Club Ice Cream (S)
saturday	Orange Juice **or** Applesauce Farina **or** Ready-to-Eat Rice Cereal Griddle Cakes, Maple Syrup Raisin Bread Toast	Minestrone Soup Swiss Steak, Country Style (F) **or** Egg Halves with Parsley Sauce (S) Buttered Potatoes (FS) Cut Wax Beans (FS) **or** Sliced Beets Chef's Salad **or** California Waldorf Salad Angel Food Cake (FS) **or** Boysenberries	Blended Vegetable Juice Sweetbreads a la King on Toast Points **or** Roast Beef au Jus (FS) Baked Potato (FS) Buttered Peas (FS) **or** Cauliflower Lettuce Wedge, French Dressing **or** Tangerine and Grapefruit with Salad Greens Norwegian Prune Pudding, Whipped Cream (F) **or** Coffee Ice Cream (S)
sunday	Orange Juice **or** Sliced Bananas Wheat Farina **or** Ready-to-Eat Malt Flake Cereal Soft Cooked Egg Sweet Rolls	Corn Chowder Baked Corned Beef Hash, Chili Sauce (F) **or** Broiled Liver and Bacon (S) Whipped Potato (FS) Braised Squash Cubes (FS) **or** Mixed Vegetables Tossed Salad Greens, Cucumbers, Radishes and Green Pepper Chips **or** Sliced Pineapple and Cheese Salad Oatmeal Cookies (F) **or** Peach Half (S)	Fruit Punch with Sherbet Roast Leg of Lamb, Mint Jelly (FS) **or** Chicken Turnover, Cream Gravy Oven Browned Potato (FS) Buttered Carrots (FS) **or** Broccoli, Lemon Butter Sliced Tomatoes on Lettuce **or** Fruit Salad, Garnished with Jellied Lime Cubes Italian Blue Plums in Syrup **or** Sponge Cake Square (FS)

(F)—Full Diet (S)—Soft Diet (FS)—Full and Soft Diet

Bread, butter and a choice of beverages are to be included with each meal.

PLEASE CUT ALONG THIS LINE

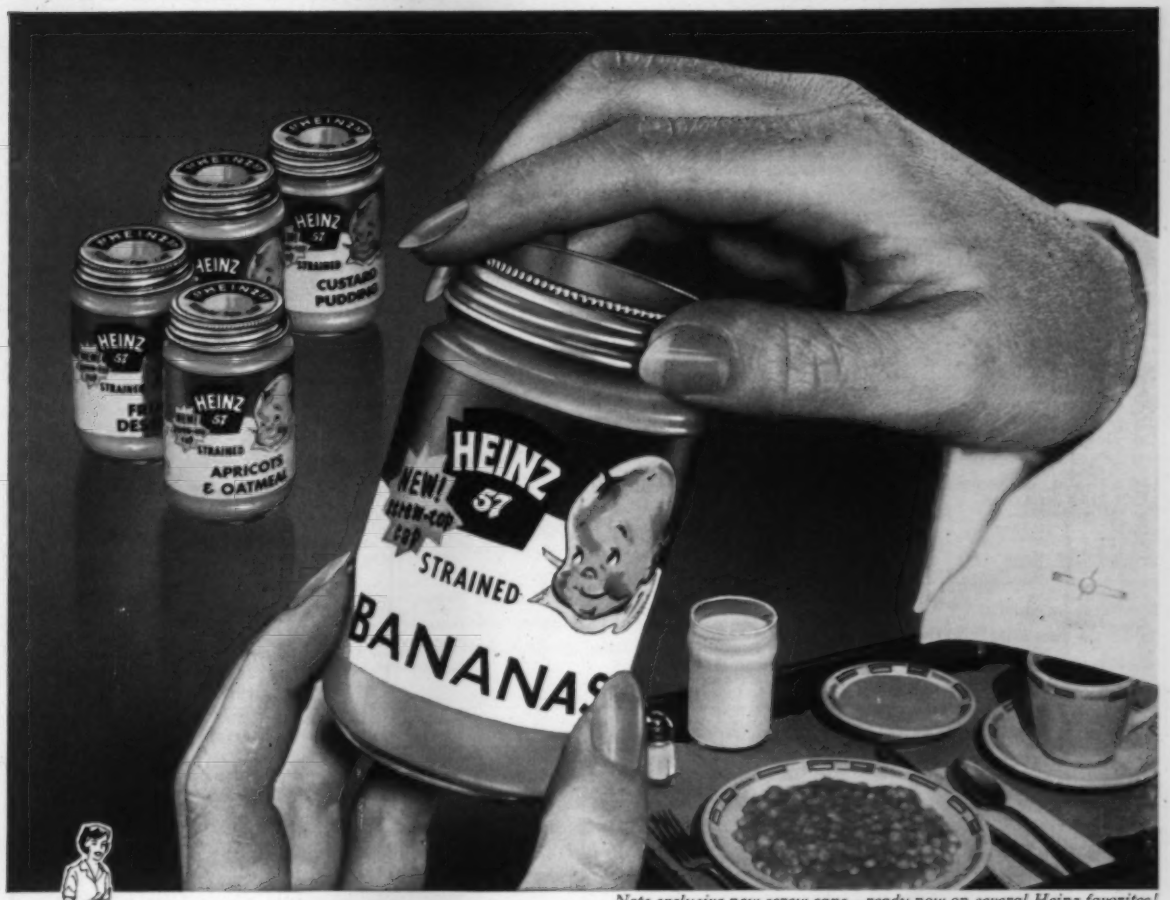
2nd week market order for perishables (per 50 beds)

Item, Specifications, Amounts & No. of Servings			
BEEF			
Brisket, Corned	U. S. Good	20 lbs.	100
Ground Beef	U. S. Good, 5 lb. pkg.	35 lbs.	
Liver	Steer, Sliced	5 lbs.	20
Roast, Sirloin (B.R.T.)	U. S. Choice	40 lbs.	120
Round (Bottom)	U. S. Standard	35 lbs.	
Steaks, Sirloin Butt	U. S. Choice, 5 oz. each	7 lbs.	20
Steak, Swiss	U. S. Good, 4 oz. each	25 lbs.	100
Sweetbreads	Fresh	5 lbs.	
LAMB			
Chops, Loin	U. S. Choice, 6 oz. ea.	15 lbs.	
Ground, Shoulder	U. S. Good	10 lbs.	40
Leg (B.R.T.)	U. S. Choice, yearling	20 lbs.	60
PORK			
Bacon (Sliced)	24-26-1 lb.	6 lbs.	
Chops, Loin	Grade A, 4 oz. each	5 lbs.	20
Ham (Pullman)	Ready-to-eat	25 lbs.	
VEAL			
Shoulder (Boneless)	U. S. Good	20 lbs.	60
FISH			
Blue Fish	Fillets, 4 oz. each	15 lbs.	60
Shrimp	26-28-1 lb.	10 lbs.	
POULTRY			
Fowl (Eviscerated)	Grade A, 5 lb. av.	20 lbs.	

Item, Specifications, Amounts & No. of Servings		
Turkeys (Eviscerated)	Grade A, 20-24 lb. av.	75 lbs.
Livers, Chicken	1 lb. pkg.	8 lbs.
FRESH FRUITS		
Apples	Jonathan, 113s	1 box
Bananas	Ripe	40 lbs.
Cranberries	25 lb. box	1 box
Grapefruit	Seedless, 70s	1 box
Lemons		1 doz.
Oranges	176s	1 box
Tangerines	Crate, 144	5 lbs.
FRESH VEGETABLES		
Beets	Topped	30 lbs.
Cabbage	Bag	20 lbs.
Cabbage, Chinese	Bag	10 lbs.
Carrots	Topped, bag	50 lbs.
Celery	White, relish	6 stalks
Celery	Pascal, 30s	3 stalks
Cucumbers		1 doz.
Eggplant		2 only
Lettuce	Head, 48s	2 crates
Onions, Dry	Yellow, bag	50 lbs.
Onions, Green	Bunch	1 doz.
Onions, White	Boilers	3 lbs.
Parsley	Bunch	1 doz.
Potatoes, Sweet	Hamper	50 lbs.
Potatoes, White	Bag No. 1	400 lbs.
Radishes	Bunch	1 doz.

Item, Specifications, Amounts & No. of Servings		
Rutabagas		5 lbs.
Squash, Acorn		25 lbs.
Squash, Butternut		25 lbs.
Squash, Hubbard		25 lbs.
Tomatoes	Repacked (5 x 6)	1 lug (30 lbs.)
Watercress	Bunch	1 doz.
FROZEN FRUITS		
Apples	8 lb. can, 5-1 sugar	24 lbs.
Boysenberries	8 lb. can, 5-1 sugar	8 lbs.
Orange Juice	Con., 32 oz. can	12 cans
Peaches	Sliced, 8 lb. can, 5-1 sugar	16 lbs.
Raspberries, Red	8 lb. can, 5-1 sugar	8 lbs.
FROZEN VEGETABLES		
Asparagus	Spears, 2½ lb. pkg.	25 lbs. 150
Beans, Green	Cuts, 2½ lb. pkg.	2½ lbs. 15
Beans, Wax	Cuts, 2½ lb. pkg.	15 lbs. 90
Broccoli	Stems and buds 2½ lb. pkg.	2½ lbs. 15
Brussels Sprouts	2½ lb. pkg.	2½ lbs. 15
Cauliflower	Buds, 2½ lb. pkg.	5 lbs. 30
Kale	2½ lb. pkg.	2½ lbs. 15
Peas	2½ lb. pkg.	20 lbs. 120
Spinach	Chopped, 2½ lb. pkg.	25 lbs. 150
Succotash	2½ lb. pkg.	2½ lbs. 15
Vegetables, Mixed	2½ lb. pkg.	5 lbs. 30

CYCLE MENU PAGES ARE PERFORATED FOR EASY REMOVAL



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3rd WEEK EAST SELECTIVE WINTER CYCLE MENU

(MENUS TO BE USED DURING DECEMBER, JANUARY AND FEBRUARY)

—prepared by Marie L. Casteen, director of dietetics, Newton-Wellesley Hospital, Newton Lower Falls, Mass.

	breakfast	noon	night
monday	Orange Juice **or** Grapefruit Half Rolled Oats Cereal **or** Ready-to-Eat Wheat Flake Cereal Scrambled Egg—Bacon Corn Muffin	Scotch Broth Oriental Eggs with Mushrooms (F) **or** Meat Loaf, Brown Gravy (S) Buttered Rice (FS) Green Asparagus Spears (FS) **or** Lima Bean Succotash Cranberry and Orange Relish Salad **or** Escarole with Russian Dressing Old Fashioned Rice Pudding (FS) **or** Fresh Fruit Citrus Sections	Chilled Apple Juice Corned Beef Brisket (F) **or** Broiled Chicken (S) Boiled Potatoes (FS) Beets and Greens (FS) **or** Buttered Cabbage Grapefruit and Diced Celery in Lemon Gelatin **or** Chef's Salad Jelly Roll (F) **or** Vanilla Ice Cream (S)
tuesday	Orange Juice **or** Blended Juice Wholewheat Cereal **or** Ready-to-Eat Oats Cereal Soft Cooked Egg Blueberry Muffin	Minestrone Soup French Toast, Maple Syrup (F) **or** Sliced Lamb, Hot Mint Sauce (S) Baked Sweet Potato (FS) Buttered Green Beans (FS) **or** Julienne Celery with Tomatoes Harlequin Cabbage Slaw **or** Orange, Apple and Watercress Salad, Celery Seed Dressing Deep Dish Raspberry Pie (F) **or** Assorted Ice Cream (S)	Pineapple Juice Chicken Chow Mein, Chinese Noodles (F) **or** Roast Sirloin of Beef (S) Potato Puff Balls (FS) Buttered Peas (FS) **or** Mashed Rutabagas Romaine with Sliced Egg **or** Apricot and Cheese Salad, Green Pepper Ring Garnish Grapenuts Custard (FS) **or** Whole Orange
wednesday	Orange Juice **or** Stewed Prunes Farina **or** Puffed Rice Cereal Dropped Egg on Toast Raisin Whole Wheat Muffin	Temple Orange Baked Cheese Strata, Sautéd Julienne Ham (F) **or** Sliced Turkey, Cranberry Jelly (S) Parslied Potatoes (FS) Buttered Spinach (FS) **or** Creamed Parsnips Crisp Green Salad **or** Fresh Fruits Tossed in Salad Greens, Dressing Sugar Cookies and Applesauce (FS) **or** Baked Chocolate Pudding	Tomato Juice Braised Pot Roast, Brown Gravy (FS) **or** Smoked Tongue, Horseradish Sauce Baked Potato (FS) Buttered Carrots (FS) **or** Broccoli Celery Heart, Olives and Radish Rose **or** Sliced Pears and Peaches in Raspberry Gelatin Cherry Tapioca, Whipped Cream (FS) **or** Whole Banana
thursday	Orange Juice **or** Pineapple Juice Rolled Wheat Cereal **or** Ready-to-Eat Wheat Flake Cereal Soft Cooked Egg Date Muffin	Beef Barley Soup Broiled Liver and Bacon (FS) **or** Cold Cuts, Potato Salad Franconia Potatoes (FS) Buttered Peas (FS) **or** Corn Pudding Cardinal Salad **or** Orange, Banana and Date Salad Blueberry Cupcake (F) **or** Peeled Apricot Halves in Syrup (S)	Cranberry Juice Cocktail Oven Browned Chicken Leg, Cream Gravy (FS) **or** Grilled Link Sausage, Baked Apple Mashed Potato (FS) Whole Buttered Beets (FS) **or** Mixed Vegetables Avocado and Grapefruit Salad **or** Sliced Tomatoes Queen's Pudding (FS) **or** Lemon Sherbet
friday	Orange Juice **or** Grape Juice Farina **or** Ready-to-Eat Cereal Poached Egg on Toast Rye Meal Muffin	New Englander Clam Chowder Salmon Salad Roll, Lettuce Garnish Sweet Mixed Pickle (F) **or** Sliced Roast Veal (S) Paprika Potatoes (FS) Buttered Green Beans (FS) **or** Hot Cream Slaw Peach Cup Salad with Watercress and Fruit **or** Lettuce, Roquefort Cheese Dressing Pumpkin Pie (F) **or** Vanilla Ice Cream (S)	Blended Vegetable Juice Broiled Eastern Halibut, Shrimp Sauce (FS) **or** Club Sandwich Escalloped Potatoes (FS) Buttered Carrots (FS) **or** Brussels Sprouts Chef's Salad **or** Watercress Bouquet in Lettuce Cup with Apple Slices Ice Cream Puff, Chocolate Sauce (F) **or** Royal Anne Cherries (S)
saturday	Orange Juice **or** Apple Juice Wheat Farina **or** Corn Flakes Griddle Cakes, Maple Syrup—Bacon Cinnamon Roll	Fruit Cup with Sherbet American Chop Suey (F) **or** Broiled Sirloin Steak (S) Whipped Potatoes (FS) Green Asparagus (FS) **or** Buttered Onion Rings Tossed Green Salad, French Dressing **or** Pear Half with Diced Fruit and Grated Cheddar Cheese Brownies (F) **or** Nectarines in Syrup (S)	Beef Broth Roast Leg of Lamb, Mint Jelly (FS) **or** Creamed Chipped Beef on Toast Baked Potato (FS) Buttered Beets (FS) **or** Broccoli, Butter Sauce with Lemon Sliced Tomato Salad **or** Jellied Vegetable Ribbon Salad Orange Custard (FS) **or** Frozen Pudding
sunday	Orange Juice **or** Apricot Nectar Rolled Oats Cereal **or** Ready-to-Eat Rice Cereal Soft Cooked Egg Raisin Bread Toast	Chicken-Rice Soup Welsh Rarebit on Rusk (F) **or** Broiled Loin Lamb Chop (S) Potato Patties (FS) Butternut Squash (FS) **or** Whole Kernel Corn in Cream Kidney Bean, Egg and Pickle Salad **or** Celery Heart, Kosher Midget Pickles Ice Box Cookies (F) **or** Elberta Diced Peaches (S)	Chilled Cider Roast Beef au Jus (FS) **or** New England Beef Stew with Vegetables French Fried Potatoes (F) Buttered Peas (FS) **or** Escalloped Tomatoes (S) Waldorf Salad **or** Red and Green Cabbage with Mixed Salad Greens Sultana Roll, Almond Cherry Sauce (F) **or** Baked Apple (S)

(F)—Full Diet (S)—Soft Diet (FS)—Full and Soft Diet

Bread, butter and a choice of beverages are to be included with each meal.

3rd week market order for perishables (per 50 beds)

Item, Specifications, Amounts & No. of Servings			
BEEF			
Brisket, Corned	U. S. Good	20 lbs.	60
Chipped Beef, Dried	U. S. Good	1 lb.	
Ground Beef	U. S. Good, 5 lb. pkg.	5 lbs.	
Liver	Steer, sliced	20 lbs.	80
Roast, Sirloin (B.R.T.)	U. S. Choice	30 lbs.	
Round (Bottom)	U. S. Standard	20 lbs.	60
Steaks, Sirloin Butt	U. S. Choice, 5 oz. each	7 lbs.	
Stew	U. S. Good	5 lbs.	20
Tongue	No. 1	7 lbs.	
LAMB			
Chops, Loin	U. S. Choice, 6 oz. each	8 lbs.	
Leg (B.R.T.)	U. S. Choice, yearling	30 lbs.	
PORK			
Bacon (Sliced)	24-26-1 lb.	12 lbs.	
Ham (Pullman)	Ready-to-eat	35 lbs.	
Sausage Links	12-1 lb.	5 lbs.	
VEAL			
Chop Suey Meat	U. S. Good	25 lbs.	100
Leg (B.R.T.)	U. S. Good	7 lbs.	
FISH			
Halibut	Steaks, 5 oz. each	20 lbs.	
POULTRY			
Fowl (Eviscerated)	Grade A, 5 lb. av.	60 lbs.	
Legs, Chicken	Grade A, 5 oz. each	20 lbs.	
Turkeys (Eviscerated)	Grade A, 20-24 lb. av.	15 lbs.	
Fryers (Eviscerated)	Grade A, 2½ lb. av.	12 lbs.	
PREPARED MEATS			
Assorted Cold Cuts		15 lbs.	
FRESH FRUITS			
Apples	Jonathan, 113s	1 box	
Avocado	Ripe	6 only	
Bananas	Ripe	25 lbs.	
Cranberries	1 lb. bag	3 lbs.	
Grapefruit	Seedless, 70s	1 box	
Grapes	Seedless, 28 lb. box	1 box	
Lemons		1 doz.	
Oranges	176s	1 box	
FRESH VEGETABLES			
Beets	Topped	45 lbs.	
Cabbage	Bag	50 lbs.	
Cabbage, Red		5 lbs.	
Carrots	Topped, bag	50 lbs.	
Celery	Pascal, 30s	3 stalks	
Celery	White, relish	1 doz. stalks	
Cucumbers		1 doz.	
Escarole	Heads	6 heads	
Lettuce	Head, 48s	2 crates	
Onions, Dry	Yellow, bag	50 lbs.	
Onions, Green	Bunch	1 doz.	
Onions, Spanish-type		3 lbs.	
Parsley	Bunch	1 doz.	
Parsnips		5 lbs.	
Peppers, Green		½ doz.	
Potatoes, Sweet	Hamper	50 lbs.	
Potatoes, White	Bag No. 1	400 lbs.	
Radishes	Bunch	1 doz.	
Romaine		6 heads	
Rutabagas		5 lbs.	
Squash, Butternut		25 lbs.	
Tomatoes	Repacked (5 x 6)	1 lug (30 lbs.)	
Watercress	Bunch	20 bunches	
FROZEN FRUITS			
Cherries	Sugar, pitted, 8 lb. can	16 lbs.	
Orange and Grapefruit Sections	Fresh, chilled, gallon	1 gal.	
Orange Juice	Con., 32 oz. can	12 cans	
Raspberries, Red	8 lb. can, 5-1 sugar	24 lbs.	
FROZEN VEGETABLES			
Asparagus	Spears, 2½ lb. pkg.	15 lbs.	90
Beans, Green	Cuts, 2½ lb. pkg.	30 lbs.	180
Broccoli	Stems and buds 2½ lb. pkg.	20 lbs.	120
Brussels Sprouts	2½ lb. pkg.	2½ lbs.	15
Peas	2½ lb. pkg.	35 lbs.	210
Spinach	Chopped, 2½ lb. pkg.	15 lbs.	90
Succotash	2½ lb. pkg.	2½ lbs.	15
Vegetables, Mixed	2½ lb. pkg.	2½ lbs.	15

PLEASE CUT ALONG THIS LINE

CYCLE MENU PAGES ARE PERFORATED FOR EASY REMOVAL

Growing use of radioisotopes demands clear-cut procedures for

HANDLING AND PROCESSING RADIATION CONTAMINATED LINEN

by E. H. MUNGER

The growing use of radioactive isotopes—many of them administered in solution—for both diagnostic and treatment purposes has created the need for clearly stated procedures for handling linen contaminated by radiation, the author states. He suggests that linen contamination problems be discussed with a physicist whenever possible.

THE LAUNDRY manager of a hospital is, of course, directly responsible for the processing of linen contaminated by radiation. In formulating procedures for accomplishing this, a laundry manager has many sources of help available. For example:

- In most hospitals, some officer, often a physicist, is responsible for determining general policies relative to radiation protection. Policies for handling radioactive linen come within his scope. The laundry manager can confer with the physicist to see what methods other than the routine laundry procedure are needed to insure that linen is thoroughly decontaminated.
- The National Committee on Radiation published its first handbook in 1923 outlining protection policies. It was revised in 1953 and is in the process of being revised a third time.
- In some areas, state health departments have adopted recommended radiation safety measures and all institutions using such materials are checked to see if these regulations are observed. It would be wise for each institution's laundry manager to see if the state in which the hospital is located has such a law. If so, copies of the legislation provide source material for answering specific questions which may arise.

The three main sources of radiation are x-ray equipment, radium, and radioactive isotopes. Since the x-ray machine produces energy only when it is in operation, and since radium is enclosed in some type of applicator when used for therapy, they present no linen hazards. Radioactive isotopes present the greatest problem to the laundry manager. The use of radioactive isotopes has increased both for diagnostic and treatment purposes. The most common radioactive isotopes used are those of cobalt, gold, iodine, and phosphorous.

E. H. Munger is laundry manager, The University of Texas M. D. Anderson Hospital and Tumor Institute, Texas Medical Center, Houston, Tex.

HOW LINEN IS CONTAMINATED

The hazard to linen occurs because many radioactive isotopes are given in solution, directly into a vein or body cavity where spillage can and does occur. Linen may become contaminated in the operating room where such procedures are done or on the nursing units where patients are confined. Procedures for handling linens from the operating rooms and the wards need to be established. The important thing to remember in this regard is that the so-called activity of radioactive isotopes decreases over a period of time. That is, the patient who received radioactive material is more radioactive the first day than on the eighth day.

The University of Texas M. D. Anderson Hospital and Tumor Institute at Houston, Tex., has a standard decontamination procedure for use in the operating room. The physics department has responsibility for ascertaining the amount of radioactivity in the linen and in the operating room itself. A member of the physics department, by using a monitor, determines the level of radioactivity. All contaminated materials are placed in heavy paper bags, tied, and sent to the decontamination storage area. There they remain until it is determined by monitoring that they can be safely sent to the laundry.

A similar procedure is followed on nursing units. When the patient has been returned to the unit from the operating room, nursing personnel are alerted to watch for any spillage of urine, feces, or peritoneal drainage. Patients who have had large doses of radioactive iodine and have perspired profusely are also considered as having contaminated linen. All such linens are placed in a heavy paper bag and sent to the decontamination storage area where they are kept until safe to be sent to the laundry. Of course, using this storage technique requires a larger stock of linen than would otherwise be required.

MONITORING DEVICE NEEDED

The following steps should be taken by institutions that do not have a physicist on the radiation protection service:

1. A suitable monitoring device should be purchased. An employee should then be trained to use it according to an established level at which linen is considered dangerously radioactive.
2. A garbage can with lid should

DECONTAMINATION OF COTTON FABRIC

Commercial laundry procedure	Temperature of solution	Cumulative per cent removal SR-89	P-32	I-131
1. Break—alkaline one per cent	110°F	25.2	26.9	86.7
2. Suds—soap one per cent	110°F	60.8	65.3	97.8
3. Suds—soap one per cent	110°F	74.6	88.4	99.2
4. Hot rinse—water	170°F	84.4	95.4	99.7
5. Hot rinse—water	170°F	85.4	96.1	100.0
6. Hot rinse—water	170°F	85.6	96.2	—
7. Sour 3 per cent citric acid	110°F	98.2	97.5	—
8. Rinse water	110°F	99.8	97.5	—

Duration of each wash and rinse is 5 minutes.

be purchased and used to store contaminated linen until it is determined by monitoring that the linen is safe to be washed in the regular manner.

Methods for washing radioactive fabrics depend largely upon the form of the contaminants. For example, water soluble salts of radioactive metals are best removed by sequestering agents in water alone. Radioactive dust of the same metal as an oxide, however, is best removed by washing with soap. These are further reasons why each problem should be discussed with a physicist, when this is possible.

In the study of radioactive materials, several washing procedures have been tried by various agencies. However, the amount of research applied to laundry decontamination problems has been far from complete.

A study* made by Talboys and Spratt, Johns Hopkins University, Baltimore, undertook to attack the waste disposal problem at its source, in the laundry itself. In the test described in this study, small pieces of uniforms, coveralls, laboratory coats, and hospital bedding were contaminated with isotopes used in research and therapy as well as some fission products commonly encountered at atomic energy installations. The radioactive contaminants most commonly used in the test were strontium-89, phosphorus-32, and iodine-131. The isotopes were studied individually, rather than in mixture, so that the effects of the different agents could be clearly described.

In the report on the tests, a number of washing formulas are illustrated step by step, listing commercial laundry procedure, supplies used, temperature of solution, and per cent of removal of contamination. This information is summarized in the chart above. The following conclusions are based on the numbered procedures shown on the chart:

Procedure 1: In practical laundry procedures, the use of lesser amounts of soap that produce suds would be necessary. The amount indicated would produce suds that could not be contained in a laundry washer and might spread the contamination around the floor.

Procedure 2: This procedure gave 99.8 per cent removal of phosphorus-32, and 100 per cent removal of iodine-131.

Procedure 3: The soda ash may have precipitated strontium carbonate and the soap may have formed insoluble soap with strontium.

Procedure 4: High temperatures for suds bath would be more effective.

Procedure 5: More rinses would be needed in plant practice to reduce the amount of citric acid on the fabrics to avoid tensile strength loss.

Procedure 6: As with other soils there is little to be gained by running decontaminating baths longer than five minutes.

Procedure 7: Underloading of washing machines apparently speeds up the removal of radioactive materials.

Procedure 8: Pretreatment such as starching and waterproofing of fabrics fails to prevent penetration and does not make removal easier. Some may make removal more difficult. ■

*For source, see first reference in the bibliography at the end of this article.

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NOTES AND COMMENT

Feather pillows not difficult to wash

Feather pillows are not difficult to wash, providing precautions are followed. Feathers are classified as a protein fiber and should be treated the same as wool fibers.

The ticking, usually made of cotton and usually more soiled than the feathers, will not launder to the same degree of efficiency as the feathers. Don't expect the ticking to be spotless.

The following instructions will produce satisfactory results:

1. Examine each ticking for worn or weak portions along the edges.

2. Repair weak or worn ticking or put the feathers into new tick-

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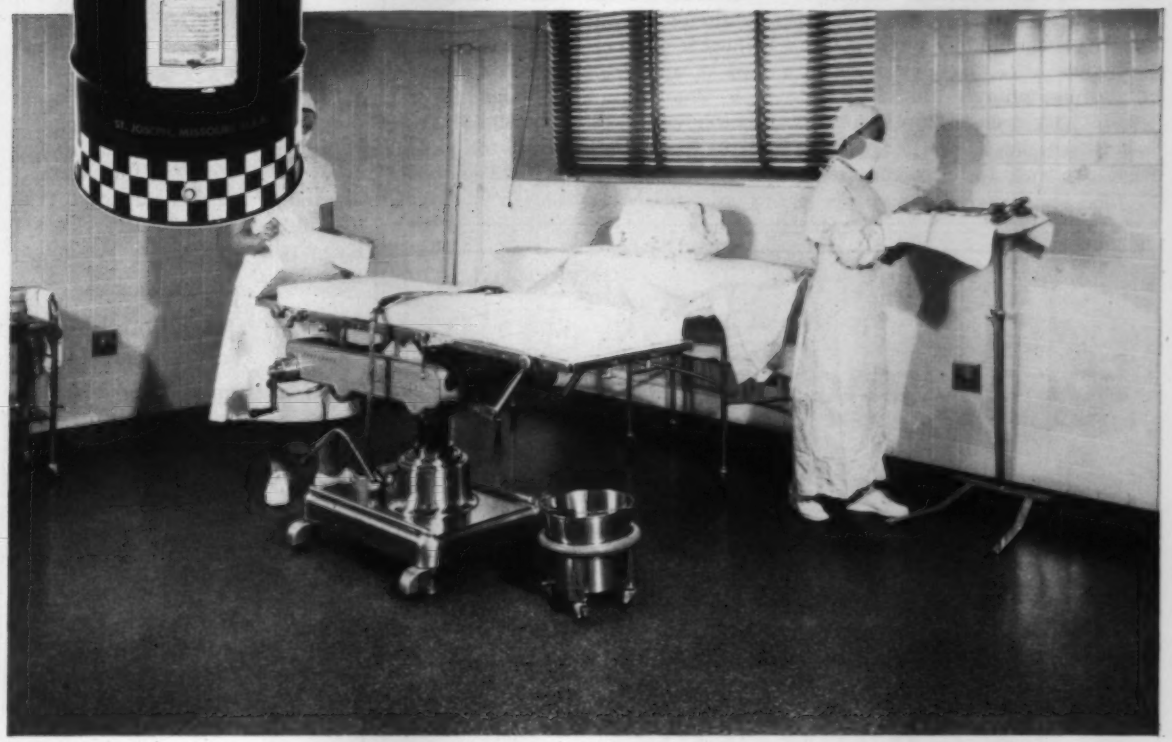

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ing before laundering to prevent the pillows from coming apart during cycle.

3. As a precaution, put each pillow into a closely knit laundry net.

4. Load the washwheel to half of normal recommended capacity. This will produce better results.

5. If your plant has a dual speed washwheel, use the slower speed in washing pillows (10-12 rpm.)

6. If your water supply is soft or softened, use a low titer neutral soap, one that does not contain a builder (alkali) and will dissolve readily in lukewarm water.

7. If your water supply is hard, use a neutral synthetic detergent, that does not contain a builder. Alkalies are harmful to feathers.

8. Add enough neutral soap or synthetic detergent to the washwheel to produce a soap concentration of approximately .2 per cent.

9. The suds baths and rinses should be lukewarm (90-100°F).

10. Keep water levels on suds bath and rinses at 10-12 inches, depending on the diameter of the washwheel.

11. Stop the washwheel cylinder during each fill and dump operation—that is, do not run the washwheel while it is dumping or filling.

12. Normally one or two 5-minute suds baths and four 2-minute rinses are adequate.

13. Give pillows a good extraction.

14. The extracted pillows may be dried in a drying tumbler at a low temperature or air dried. Fluff the pillows periodically.—JOSEPH KRAWIEC, *writing in* American Laundry Digest.

For a Handy Purchasing Reference

see the

GUIDE FOR HOSPITAL BUYERS

on the Goldenrod pages

Part II of the Aug. 1, issue

HOSPITALS

Journal of the American Hospital Association

18 E. Division Street Chicago 10, Illinois

Bleaching method for woolen fabrics

White woolen blankets over a period of time become discolored or yellowed to a certain degree. The use of chlorine bleach solution is definitely not recommended for bleaching purposes, because of its detrimental effect on the wool fiber.

Discolored white woolen blankets or white woolen fabrics may be restored to their original whiteness by bleaching them with a solution of hydrogen peroxide or a solution of sodium perborate.

Hydrogen peroxide and sodium perborate are very slow in their bleaching action. A soaking period of 30 minutes to two hours may be required for effective bleaching.

Using a solution of 2 to 3 ounces of sodium perborate to every 5 gallons of lukewarm water (100°F.) is satisfactory for bleaching purposes. Stronger solutions of sodium perborate are more difficult to control and may result in tendering of wool fiber.

In hydrogen peroxide bleaching, a solution of 2 to 3 ounces of 100-volume (strength) hydrogen peroxide or 8 to 12 ounces of 25-volume hydrogen peroxide per 5 gallons of water will give good results.

After the bleaching treatment, it is very important to rinse the woolens thoroughly before extracting and drying them. This bleaching treatment may also be used to brighten the white background on colored woolen fabrics. —JOSEPH KRAWIEC, *writing in* American Laundry Digest.

book reviews

Budgets as management aid

also:
conference report
administration of Virginia mental hospitals

BUDGETING AND COST ANALYSIS FOR HOSPITAL MANAGEMENT. Leon E. Hay. Bloomington, Ind., University Publications, 1958. 205 pp. $6.25.

This text explains how cost analysis and budgeting can be used as important tools of hospital management.

Management is defined as "that group responsible for planning, organizing, and controlling the activities of the organization". Budgeting and cost analysis are regarded as management accounting techniques which can aid management in performing its responsibilities more effectively.

The book contends that "properly done and properly interpreted cost analysis can:

1. Provide information for use in setting equitable rates.
2. Furnish a basis for intelligent negotiation with contract purchasers of hospital services.
3. Fulfill requirements of hospital associations and/or governmental agencies for information, or fulfill existing contracts with third-party purchasers.
4. Provide a measure of the effectiveness of the operation of various subdivisions of which costs are determined.
5. Provide a basis for planning future operations."

Concerning budgets, the text states that "budgets of successful businesses are not just financial plans, they are operational plans".

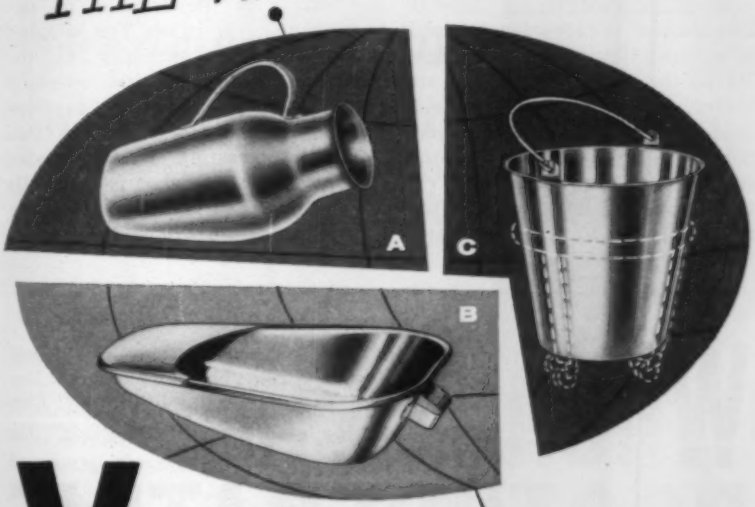
The arrangement of the text is logical, the definitions and explanations are sound and well phrased, and the illustrations are complete and easy to follow.

Although materials on cost analysis and budgeting can be found elsewhere, the point of view and the manner of presentation given in this book are most helpful. The author did not intend this work as a manual or book of directions, but the principles are so well developed and the illustrative cases so complete that the book is actually an excellent guide to cost analysis and budgeting.—V. G. EDMONDSON, *accounting specialist, Oklahoma State Hospital Association.*

Conference report

The American Association for Health, Physical Education, and Recreation has recently published a report of a conference held in

IN HOSPITALS THE WORLD OVER...



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Washington, D.C., November 17-20, 1957 entitled *Recreation for the Mentally Ill.*

Professional attitudes and practices, preservice and inservice education, and facilities and equipment are among the topics discussed. Standards, job descriptions and bibliographies are found in the appendices. Copies are available from the publisher, 1201 Sixteenth St., N.W., Washington 6, D.C. for $2.

Administration of Virginia mental hospitals

MANUAL OF STANDARD ADMINISTRATIVE PRACTICES AND PROCEDURES. Virginia Division of Mental Hospitals. Richmond, The Division, 1957.

In an "introductory statement" this manual is labeled a guide. It is no such thing. Language used carries the intent of directives and serves the purpose of imposing specific limits on the authority delegated to hospital operating supervisors. The outstanding virtue of the publication is that nothing is left to the imagination. No doubt, it will standardize, or routinize, administrative practices in Virginia mental hospitals. That efficiency, in terms of operating performance, will be improved is questionable. Most administrators would challenge the conclusion that efficiency is synonymous with effectiveness. However, this is the stated purpose of the book.

Formal definition of Virginia mental hospital goals—the purpose for which public funds are allocated—is to "provide the best possible care for the mentally ill". Nothing is said about facilitating the effectiveness of hospital resources in returning mentally ill individuals to socially productive living.

Part I of the manual, on organization, is brief. The divided administrative authority of the Virginia mental hospital system is delineated by charts, supplemented by brief narrative comments. This is an interesting, frankly stated departure from what is generally considered a functional administrative structure.

A number of sections in Part II, "Operational Procedures," are omitted to be completed at a later date. Administrative procedures having to do with fiscal operations and control are elaborately stated. In these sections, instructions, including examples of completed report forms, are so detailed as to leave practically nothing to individual judgment or initiative. Modification is specifically prohibited.

The section on personnel administration is particularly interesting. A limiting date, as well as a limit on hourly wage, is specified upon the employment of "hourly and per diem employees". In fact, no such person may be authorized employment beyond June 30 of the fiscal year in which employment is authorized. Theoretically, all such individuals can anticipate loss of their jobs on June 30 each year unless the director of the Division of Mental Hospitals determines otherwise. The reason for such employment restriction is not stated.

Authority is delegated to the personnel officer to rank in order of fitness all applicants for employment. Such yardsticks as "capacities, abilities and interests as they relate to the position" are suggested. If operating supervisors do not select applicants of "highest rank", only the director of the Division of Mental Hospitals may approve deviation from the personnel officer's ranking. It is also worthy of note that employment of "parolees, probationers and other persons who have been convicted of a crime should be encouraged." State employment, as a means of rehabilitating social misfits, may be desirable, but the wisdom of assigning responsibility for the emotionally handicapped to individuals with social deficits is a questionable practice. It is made clear that each such employee must be carefully screened.

This manual will be of little interest or value outside the State of Virginia. It is a good example of a method of systematically centralizing administrative control of separate institutions with similar function.—LEE G. SEWALL, M.D., *manager, Veterans Administration Hospital, Perry Point, Md.*

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*Howland, W. S.: Cardiovascular and Clotting Disturbances during Massive Blood Replacement, Anesthesiology 19 (2): 140-152 (Mar.-Apr., '58).

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personnel changes

● **Alvin H. Goldberg** has been appointed director of finance and accounts, Maimonides Hospital of Brooklyn (N.Y.). He was formerly comptroller of Beth Israel Hospital, New York City.

Michael Marvald has been named administrative assistant in charge of purchasing for Maimonides Hospital. He was formerly with a surgical supply house.

Harold A. Schneider, former assistant director in charge of purchasing, has been assigned to executive office responsibilities.

● **Frank C. Haythorn** has been appointed administrator of Fifth Avenue Hospital, Huntsville, Ala. **Nathan A. Morgan,** formerly administrator of Fifth Avenue General, has been appointed administrator of Cookeville (Tenn.) General Hospital.

● **Gary R. Holdren** has been appointed assistant administrator of Mary Washington Hospital, Fredericksburg, Va. He is a graduate of the Medical College of Virginia course in hospital administration.

● **H. H. Huckabay** and **Frank A. Jerome Jr.** have been appointed assistant administrators of Baton Rouge (La.) General Hospital. Mr. Huckabay was formerly business manager of the hospital. Mr. Jerome was formerly administrative assistant. **Willard K. Wilkes** has been appointed business manager at the hospital; he was formerly assistant business manager.

● **Richard W. Hunsaker** has been appointed assistant administrator of Brockton (Mass.) Hospital. He was formerly assistant administrator of Children's Hospital, Columbus, Ohio. Mr. Hunsaker is a graduate of the University of Minnesota course in hospital administration.

● **Joseph Michael Jaskol** has been appointed assistant director of the Mountainside Hospital, Montclair, N. J.

● **Stanley F. Masson** has been appointed administrator of Rockford (Ill.) Memorial Hospital. He succeeds **John L. Brown** who has been appointed director of a hospital to be built in Syracuse, N. Y.

Mr. Masson was formerly assistant director of Touro Infirmary, New Orleans.

● **William F. McLaughlin** has been appointed director of Dade County Hospital, South Miami, Fla. He was formerly assistant director of Jackson Memorial Hospital, Miami. Both hospitals are now part of a recently established Department of Hospitals of Metropolitan Dade County, Fla.

● **Olof T. Moline** has been appointed administrator of Porter Sanitarium and Hospital, Denver. He was formerly assistant administrator of Hinsdale (Ill.) Sanitarium and Hospital. Mr. Moline has been succeeded by **Raymond L. Pelton** who was formerly chief accountant at the hospital. Mr. Moline is a graduate of the Northwestern University course in hospital administration.

● **Frank F. Morin** has been appointed

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administrative assistant at Peninsula Hospital, Burlingame, Calif. He was formerly administrative resident at the hospital. Mr. Morin is a graduate of the University of California course in hospital administration.

● **James H. Moses** has been appointed administrator of Cushing (Okla.) Municipal Hospital. He was formerly administrator of Pawnee (Okla.) Municipal Hospital.

● **John Crawford Neal** has been appointed administrative assistant of Crawford W. Long Memorial Hospital, Atlanta. Mr. Neal is a graduate of the Georgia State College of Business Administration program in hospital administration.

● **G. K. Palin** has been appointed administrator of the Lachine (Quebec) General Hospital. He was formerly administrator of the Alexandra Hospital, Montreal.

● **Vernon L. Perry** has been appointed administrator of Mojave (Calif.) Medical Center and Hospital. He was formerly clinic manager of the Miller Medical Clinic, Pomona, Calif.

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● **Margaret E. Peters** has been appointed administrator of the Institute of Physical Medicine and Rehabilitation and assistant administrator of University Hospital, New York University-Bellevue Medical Center. Miss Peters was formerly administrative assistant at Grasslands Hospital, Valhalla, N. Y.

● **Charles W. Pruitt Jr.** has been appointed assistant director of the University of Florida's Teaching Hospital and Clinics, Gainesville. He was formerly assistant in administration, office of the provost, J. Hillis Miller Health Center, University of Florida.

● **Garnett L. Radin** has been appointed director of Shriners Hospital for Crippled Children, Lexington (Ky.) Unit. She formerly served as assistant director of the hospital. Mrs. Radin is a graduate of the Northwestern University program in hospital administration and succeeds **Eleanor Baird.** Miss Baird is presently administrator of all Shriners hospitals.

● **Peter E. Swerhone** has been appointed assistant administrator of Winnipeg (Manitoba) General Hospital. He was formerly assistant administrator of Notre Dame Hospital, North Battleford, Saskatchewan. Mr. Swerhone is a graduate of the University of Toronto program in hospital administration.

Deaths

● **Arthur H. Brittingham,** administrator of Easton (Pa.) Hospital, died in his own institution on Sept. 3 at the age of 54. He had been administrator of the hospital since 1944. Mr. Brittingham had at one time been president of the Eastern Pennsylvania Regional Hospital Association and in 1951 had been second vice president of the Hospital Association of Pennsylvania.

Donald C. Richards is serving as acting administrator.

● **Sister Superior Mary Seraphim, R.N.,** died on Sept. 26, at the age of 69, following a long illness. At the time of her death she was administrator of St. Michael's Hospital, Newark, N.J., a post she had held since 1954. Sister Seraphim had also been coordinator of the training schools of hospitals operated by the Sisters of the Poor of St. Francis in the United States.

THE LAW IN BRIEF

Legal matters of interest to the hospital field prepared by the law department of the American Hospital Association

Blood Transfusions: A Problem of Evidence

Untoward results occasionally follow blood transfusions. From the standpoint of determining a hospital's liability in such instances, it is necessary to ascertain whether the injury or disease was actually caused by the transfusion, and, if so, whether hospital personnel were negligent in the administration of blood.

A Utah case helps to illustrate the legal problems inherent in a suit based upon alleged negligence in administering incompatible blood. *Joseph v. W. H. Groves Latter Day Saints Hospital*, 318 P. 2d 330 (Utah, 1957). The deceased received a transfusion in conjunction with surgery for removal of a tumor, but death resulted from inflammation of the kidneys. The plaintiff, her husband, claimed that incompatible blood was administered, which was the proximate cause of death, and that this was negligence on the part of the hospital.

The controversy over evidence ended with the state supreme court ordering a new trial. The trial court had denied to the plaintiff's counsel the opportunity of reading and commenting upon certain entries from the hospital record while before the jury. The notations had been made by attending physicians and indicated a possible blood transfusion reaction.

EXPERTS MUST APPEAR

The law in most states allows admission as evidence of medical record entries which are routine and constitute statements of fact. These would include symptoms, treatment, and orders. They would ordinarily not include medical opinions of experts. The experts must appear in court and submit to cross-examination if their opinions are to be admitted in evidence.

In this litigation the jury was required to weigh the evidence and determine whether death was caused by administration of incompatible blood. Medical witnesses for the hospital had testified that even after the autopsy it was not possible to say with any certainty that the transfusion caused the death. The plaintiff's attorney sought to counter this testimony by introducing the medical records as evidence of medical opinion favoring the transfusion as the cause of death.

UTAH, TEXAS RULINGS CONTRAST

The Supreme Court of Utah, perhaps contrary to the position in most states, determined that these entries should have been admissible as evidence, even in absence of the medical witnesses who wrote them, because they were pertinent to the care of the patient and were made by trustworthy persons engaged in medical treatment.

Two of the five justices of the Utah Supreme Court dissented, insisting that where conclusions of experts are to be considered in court, the experts themselves must be present to show their qualifications, their contact with the patient, and the extent of information upon which their conclusions are based.

In contrast, a Texas case reflects the prevailing rule regarding use of hospital records in court. The medical record of emergency hospital treatment included the entries: "Hit by car. Small laceration (superficial) . . . No evidence of any fractures or other injuries."

The appellate court held that the statement in the record about the laceration was admissible as evidence since this was a factual condition observable by anyone. Reference to the patient being struck by a car was not allowed since none of the persons at the hospital who made the entries had personal knowledge of how the injuries were received. The court also excluded the statement concerning absence of fractures since this was a conclusion and opinion of the doctor which could not be admitted as evidence without his presence in court.

The general rule, then, is that factual statements made by physicians contained in hospital records are admissible in court as evidence in the same manner as factual entries made by nurses and other hospital personnel in connection with the routine business of the institution. However, where the statement of the physician consists of opinion, conclusion, or diagnosis based upon his medical examination or findings of conditions not obvious to persons generally, the statement must be excluded at the trial unless the physician testifies. He must submit to cross-examination by opposing counsel and justify his conclusions. *Martinez v. Williams*, 213 S.W. 2d 742 (Tex. Civ. App., 1958).

Antitrust: Medicine as a Trade

Doctors denied membership in a medical society have, at times, brought suit on theories of antitrust or restraint of trade They have alleged that a conspiracy existed among certain organized physicians, and sometimes hospitals as well, to limit the practice

This material is not legal advice. The information on this page should not be used to resolve legal problems. For advice on such problems a hospital should consult a member of the local bar.

of medicine and thus make it difficult or impossible for an "outsider" to succeed in his profession.

One of the difficulties faced by such plaintiffs has been to show that the practice of medicine constitutes a 'trade" so that a concerted action to preclude a newcomer from practicing constitutes a "restraint of trade" within the meaning of the law.

A recent appellate court decision in California may portend further actions against organized medicine and hospitals by persons whose economic prospects have been curtailed as a result of purported concerted action of the professional societies.

Tatkin v. Superior Court of the State of California for the County of Los Angeles, 326 P. 2d 201 (Cal. App., 1958) was a suit brought by a physician against the county medical society, the American Medical Association, a hospital, and 62 individual defendants. He charged the defendants with conspiring to control the practice of medicine in the county in order to prevent competition between licensed physicians. Among other things, he claimed that a fee schedule was established and those who charged less than the minimum were disciplined, that the number of doctors in the area was intentionally limited, and that only members of the county medical society, in which the plaintiff had been denied membership, were admitted to staff membership in over 90 per cent of the county's hospitals. He alleged that he charged fees lower than those prescribed by the society. He also asserted that after he was refused membership in the medical society his hospital privileges were terminated without cause.

In the course of the litigation, the plaintiff sought to have the secretary of the medical society answer certain questions prior to trial, at a deposition proceeding, related to the rules and policies which the society applied in passing on applications for membership. The secretary refused and the trial court upheld him, but the appellate court ruled for the plaintiff. In order to hold that the questions must be answered, the latter court, by a 2-1 majority, first ruled that the theory on which suit was brought was valid.

Specifically, the court considered whether medicine is a "trade" within the antitrust laws, and after examining the authorities, concluded that the practice of medicine is a "trade" within the meaning of common law principles opposed to restraint of trade and under a California statute.

The dissenting justice felt that the practice of medicine was not intended to be considered "trade or commerce" within the statute on the common law respecting restraint of trade.

If the case is tried, the outcome will have significance for the organized hospital field as well as for organized medicine. It may affect policies governing listing, accreditation and membership in professional organizations, and hospital medical staff privileges.

Damages for 'Cancerophobia'

Mental anguish stemming from a fear of contracting cancer has been labeled as "cancerophobia." In a recent suit this state of mind induced a substantial judgment which was sustained on appeal.

The plaintiff suffered from bursitis and received a series of x-ray treatments administered by the defendant radiologists. The after-effects of the therapy were pain, nausea, and raw skin on her shoulder. The difficulty was diagnosed as chronic radiodermatitis. Seeking relief, she visited a dermatologist who, in the course of treatment, advised the plaintiff that she should have her shoulder checked every six months inasmuch as the burned area might become cancerous. Anxiety and phobic apprehension followed as the plaintiff reacted to the possibility of developing cancer.

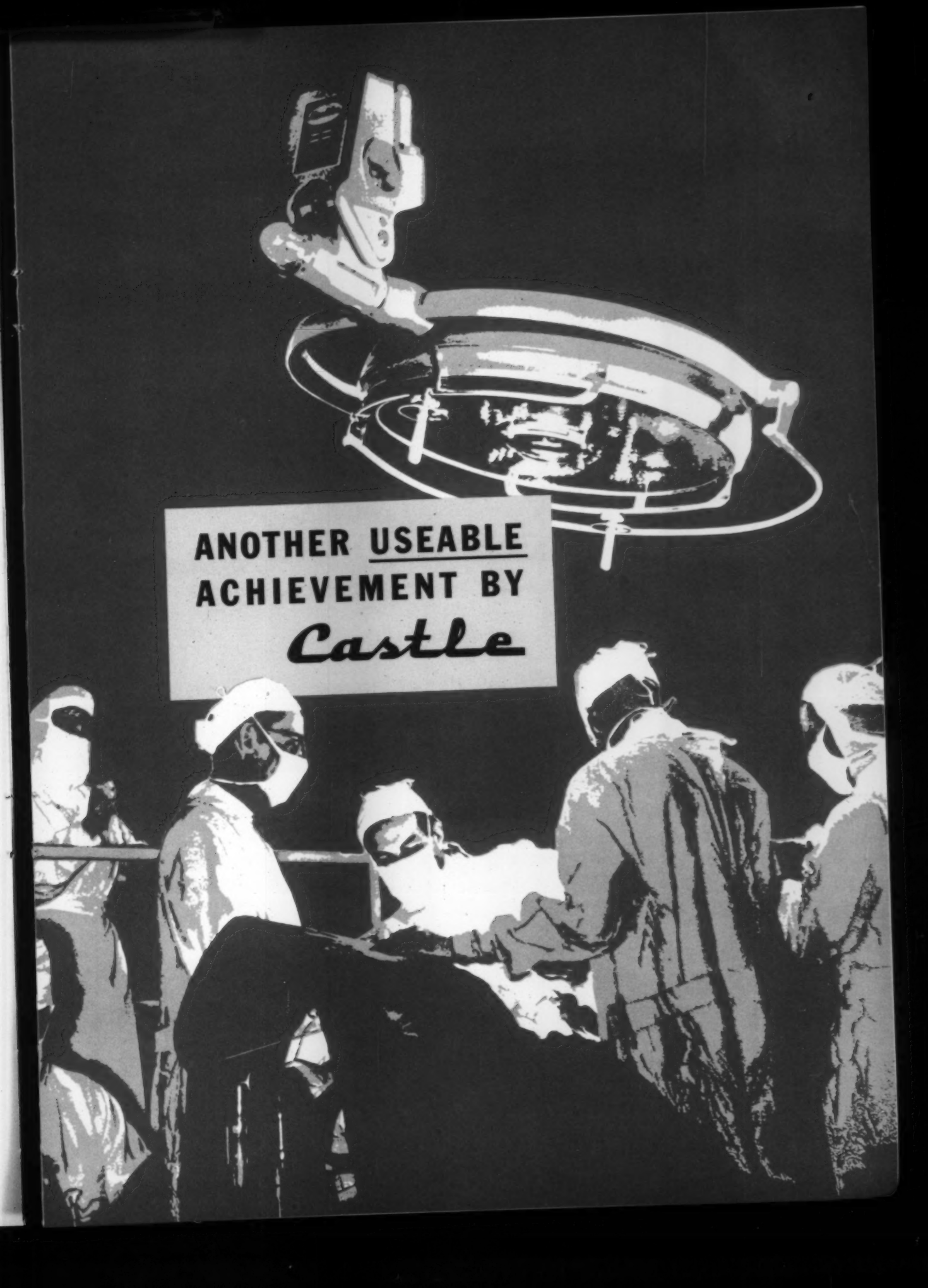
The verdict of the jury in this malpractice suit was $25,000, of which $15,000 represented damages for mental anguish flowing from cancerophobia. The defendants appealed, contesting the validity of the $15,000 award for mental anguish.

Traditionally, courts have been reluctant to base an award upon mental injury since the possibility of vexatious and fictitious suits has been ever present. In fact, three of the justices in this case, sitting in the highest court of New York State, voted to eliminate the $15,000 portion of the judgment based on mental suffering. They felt it would be dangerous to pay for the anxiety reaction of patients who hear words of caution from their doctors; too many fraudulent, unverifiable claims could result.

The majority opinion, however, recognized this type of claim for the first time in New York State. The court reasoned that the rule has been well established that a wrongdoer is liable for the ultimate result, though the mistake or negligence of the physician who subsequently treated the injury may have increased the original damage. In the instant case there was a real connection between the ultimate damage and original wrong. The dermatologist's action, however, was not considered negligent and did not aggravate the original physical injury but increased only the mental anguish attendant upon the injury. The radiologists started the chain of circumstances without which cancerophobia would not have developed, and they were considered responsible for the consequences.

How far will the New York courts carry this principle? The Court of Appeals said that public policy dictates at some remote point the original wrongdoer will cease to be liable, but that in this case neither public policy nor common sense is offended by the result. Consequently, recovery has now been allowed against an original wrongdoer for purely mental suffering arising from information the plaintiff-patient received from another doctor to whom she went for treatment of the original injury.

Does this open the door to vexatious suits and fictitious claims? Certainly mental disturbances can be simulated. The court felt that this is simply a problem of proof. Fright, shock, and other kinds of mental injury are marked by definite physical symptoms capable of clear medical proof. Where the evidence indicates the claim of mental injury is genuine, the court thought there should be no barrier to a verdict. For example, in this suit there was testimony of a neuropsychiatrist to corroborate the rather credible story of the plaintiff. *Ferrara v. Galluchio,* 8 Neg. Cas. 2d 535 (N.Y., 1959).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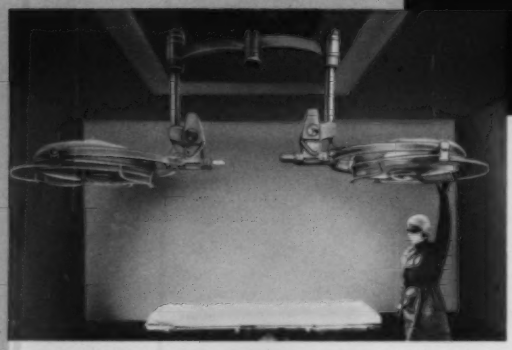

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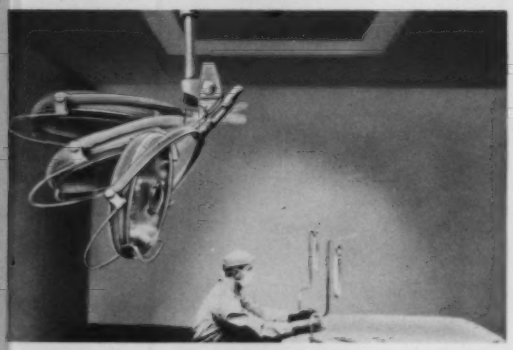

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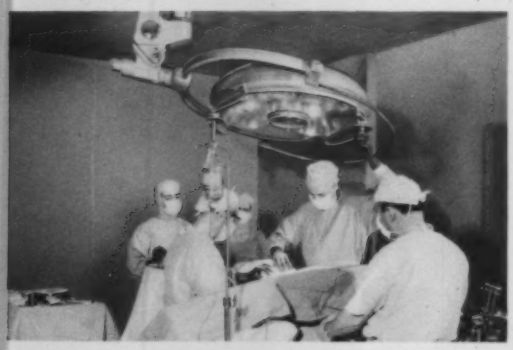

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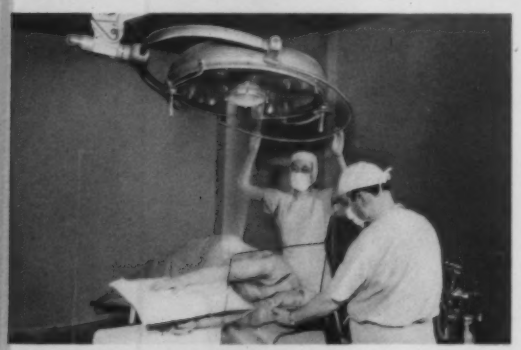

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Blue Cross Investigation Planned

Congress is preparing to hold extensive public hearings during the winter on Blue Cross rates and hospital costs across the country.

SEN. MORSE

A Senate subcommittee chaired by Sen. Wayne Morse (D-Ore.) is already investigating "the whole matter of medical costs" in the local Washington, D.C. area. Sen. Morse said the subcommittee will look into the need for greater "public representation" on Blue Cross boards and whether Blue Cross "takes steps" to curtail costs in participating hospitals.

The study follows announcement of a 42 per cent increase in rates, effective Sept. 1, by Group Hospitalization Inc., the Blue Cross Plan in the District of Columbia area. The subcommittee was requested to make the investigation by the local American Federation of Labor-Congress of Industrial Organizations. The AFL-CIO group expressed concern that older retired persons could not afford the new rates.

Sen. Morse is chairman of the Public Health Subcommittee of the Senate District of Columbia Committee. While this committee has jurisdiction over local District of Columbia matters only, its hearings are expected to be of nation-wide interest. Sen. Morse has ordered the subcommittee staff to compare local D.C. Blue Cross rates and hospital costs with those found in other parts of the country. Proposed legislation concerning Group Hospitalization's rate-setting authority would come before the full Congress for debate and vote.

Congress serves as a combined city council and state legislature on local District of Columbia laws. In this role, Congress chartered Group Hospitalization Inc. as a nonprofit organization in 1939. The plan now has 760,000 subscribers.

The legislation proposed by subcommittee members would give the commissioners of the District authority to set Group Hospitalization rates. The District's three commissioners are appointed by the President.

The subcommittee bill would increase Group Hospitalization's board of trustees to 13 members, 7 appointed by the District commissioners, 3 by participating hospitals, and 3 by the District Medical Society. At present the board consists of nine members, three appointed by each of these interests.

The bill would also require Group Hospitalization to announce rate increases 90 days in advance. The commissioners would be given authority to then approve or disapprove the increase after public hearings were held.

Sen. Morse has announced that a redraft of this bill for introduction in Congress during the next session may give the commissioners even broader jurisdiction in rate setting. He indicated agreement with Robert E. McLaughlin, president of the board of commissioners, that the commissioners should be given authority to roll back existing Group Hospitalization rates as well as determine rate increases, and that they presently have authority to examine pertinent books and records.

States to Run Study Aid Program

Proposed withdrawal of federal administration of the practical nurse program was announced by Health, Education, and Welfare Secretary Arthur S. Flemming at his third press conference since Congress adjourned. He took the opportunity to announce plans for cutting back federal participation in water-pollution-control programs and some vocational education projects, including the practical nurse program.

Secretary Flemming favors turning back certain health and welfare programs to the state. States will be asked to carry a greater share of the fiscal burden of these programs under a plan whereby the federal government would forego 30 per cent of the present federal telephone tax in order that this source of revenue would be available to the states. This is the same scheme put forward by President Eisenhower in his budget message last year. In addition however, Secretary Flemming also announced that a new sliding-scale formula would be used to distribute federal grants among the states, with relatively larger grants going to the lower income states.

In his prepared statement, Secretary Flemming said the new formula "would make available to the states approximately $145 million in federal revenue to cover the cost of the present $85 million in annual federal grants for waste-treatment construction and vocational education."

The secretary went on to explain that each state would receive more than the value of the present federal grants for these programs. Under his plan, Flemming said, "the states would be expected to assume responsibility for supporting and administering these two programs."

Graduate Nurse Traineeships

Doubled federal appropriations for graduate nurse training will permit 39 additional schools of nursing to receive federal traineeship funds this year.

Sixty schools have already received federal funds during the first two years of the program.

The Public Health Service announced that an estimated 1500 registered nurses will receive traineeship grants under the $6 million appropriated by Congress for fiscal 1959. The previous year's appropriation was $3 million.

Meanwhile, a report based on the recommendations of nursing and health leaders for extension and possible changes in the traineeship program is being

prepared for presentation to Congress in January. The three-year program will expire next summer unless Congress votes to extend it.

The traineeships are awarded for graduate study by professional nurses interested in upgrading their training for administrative and teaching positions. PHS announced that a limited number of this year's traineeship awards will be given to registered nurses now enrolled in baccalaureate programs in nursing.

The 39 schools of nursing which will receive traineeship funds for the first time this fiscal year are:

Alabama: School of Nursing, Tuskegee Institute, Tuskegee.

Arkansas: School of Nursing, University of Arkansas, Little Rock.

California: School of Nursing, Chico State College, Chico; School of Nursing, San Francisco State College, San Francisco; School of Nursing, San Jose State College, San Jose; School of Nursing, University of San Francisco, San Francisco.

Colorado: School of Nursing, Loretto Heights College, Loretto; School of Nursing, University of Denver, Denver.

Connecticut: School of Nursing, University of Bridgeport, Bridgeport.

District of Columbia: School of Nursing, Georgetown University.

Florida: School of Nursing, University of Miami, Coral Gables.

Illinois: School of Nursing, Loyola University, Chicago; School of Nursing, University of Illinois, Chicago.

Kentucky: School of Nursing, Nazareth College, Louisville.

Louisiana: School of Nursing, Louisiana State University, New Orleans; School of Nursing, Northwestern State College, Natchitoches.

Mississippi: School of Nursing, University of Mississippi, Jackson.

Missouri: School of Nursing, College of St. Teresa, Kansas City; School of Nursing, University of Missouri, Columbia.

New Hampshire: School of Nursing, St. Anselm's College, Manchester.

New Jersey: College of Nursing, Rutgers University, Newark; School of Nursing, Seton Hall University, Newark.

New York: School of Nursing, Adelphi College, Garden City; School of Nursing, Russell Sage College, Troy; School of Nursing, State University Teachers College, Plattsburg; School of Nursing, Wagner College, Staten Island.

North Carolina: Division of Nursing Education, Duke University, Durham.

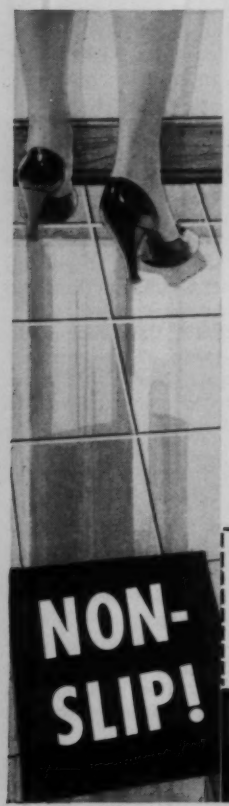
Ohio: School of Nursing, College of Mt. St. Joseph-on-the-Ohio, Mt. St. Joseph.

Pennsylvania: School of Nursing, Duquesne University, Pittsburgh; School of Nursing, Villanova University, Villanova.

South Carolina: School of Nursing, University of South Carolina, Columbia.

Tennessee: School of Nursing, University of Tennessee, Memphis.

Texas: School of Nursing, Baylor University, Waco; School of Nursing, Incarnate Word College, San An-



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VA Building Program Spurred

Expenditures of approximately $70 million, including record sums for renovation projects, are to be made this fiscal year by the Veterans Administration.

While construction expenditures will not be as large as those in the postwar construction spurt, they will surpass any since 1951. Congress also appropriated more funds for VA inpatient care than had been requested in the proposed budget.

Of the $70 million for 1959 construction, $30 million will go for renovation and modernization. This represents the largest VA renovation program of any year. The remaining $40 million will go for new and replacement hospital construction during 1959.

Congress added $10 million more than requested in the budget, specifically to accelerate modernization and improvement. It did so upon recommendation of the House Appropriations Committee. The committee reported that it "cannot understand why it is taking so long to make any progress with the hospital renovation program." It stated that it "will expect an increased number of projects to proceed into construction without delay and will review the situation next year."

VA's $70 million construction program for fiscal 1959 is $6 million more than was spent for this purpose in fiscal 1958, and $48 million more than in 1957. The 1959 sum is the highest since the $104 million spent in 1951. The postwar peak was $225 million in 1948.

The 1958 sum included $20 million for renovation, $17 million of this going for large scale modernization programs, and the remaining $3.4 million for smaller projects. More than $41 million was spent during 1958 for new and replacement construction and some $2 million for portable hospital equipment.

Even with the record 1959 construction, VA does not expect to appreciably raise its current level of approximately 121,000 operating beds. Some beds, such as those in tuberculosis facilities, are being closed and many new construction projects will not be completed within the year. Democratic members of the ever vigilant House Veterans Affairs Committee are again preparing to introduce their bill to set a statutory limit of 125,000 operating beds for the Veterans Administration. This bill was introduced late in the last Congress and approved by the House Veterans Committee to indicate committee disagreement with VA policies on closing beds.

In fact the increased appropriation for both VA hospital construction and inpatient care reflect the discontent of Democratic leaders in Congress with Eisenhower administration cutbacks on VA budgets. The Democratic Congress voted $8.3 million more for inpatient care in fiscal 1959 than had been requested. The 1959 appropriation was $715,465,000. This is $13.4 million more than the 1958 appropriation. Figures are for inpatient care in both VA hospitals and domiciliary facilities.

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3 GROUPS IN DISPUTE—

Wisconsin Health Plans' Rift Widens

Wisconsin hospitals, having given the state's Blue Cross Plan a vote of confidence through the Wisconsin Hospital Association, are awaiting developments in the controversy which has enveloped the state's three nonprofit health care plans for more than a decade.

The three health care plans involved are (1) Associated Hospital Service (Blue Cross, operating state-wide) which is the sales agent for the second health care plan, Surgical Care, the Blue Shield Plan of the Medical Society of Milwaukee County. Until last February, Associated Hospital Service was selling the third plan, Wisconsin Physicians Service of the State Medical Society of Wisconsin (also Blue Shield) throughout Wisconsin except for Milwaukee. Before February, Surgical Care had been marketed in Milwaukee County only. It is now sold state-wide.

The dispute concerns the county society's right to market Blue Shield on a state-wide basis, in the face of the state medical society's announced opposition. Antipathy between Wisconsin Physicians Service and Blue Cross is also basic to the controversy.

Most recent manifestation of the controversy was the Sept. 27 resignation of Dr. Jerome W. Fons from the presidency of the State Medical Society of Wisconsin during a special session of the society called to discuss the Blue Shield problem.

DISCUSSION REJECTED

Dr. Fons' resignation was precipitated by rejection by the state society's House of Delegates of a resolution introduced by Dr. Fons which would have established a five-man lay committee as an advisory board for Wisconsin Physicians Service to consult and discuss mutual problems with a Surgical Care advisory group.

Instead of adopting Dr. Fons proposal, the House, by a vote of 55 to 22, favored a resolution sponsored by the Dane County (Madison) Medical Society that there be established:

"One Blue Shield Plan to serve the State of Wisconsin under the direction of the House of Delegates of the State Medical Society of Wisconsin, and

"That in deference to 'home rule,' any county society unit may operate a branch of the mother plan within that county society's geographical limits and under the direction of the majority of the physicians practicing within those geographic limits."

The House also ruled that a county society selling its version of Blue Shield on a state-wide basis on Dec. 31, 1958, would face expulsion from the state organization. Should the county group be expelled a rival county organization might have to be established, the House stated.

ISSUE OF LAW

The county Blue Shield Plan contended that since it at one time received permission from the state society to operate a surgical-medical plan on a state-wide basis, under state law the state group cannot retract its permission.

Dr. S. A. Morton, president of the county society which represents some 1100 of the state's approximately 4000 doctors, stated that his group would probably continue to sell Blue Shield outside the Milwaukee area and, if necessary, hold back dues payments from the state society. The state society gets approximately one-third of its income from the Milwaukee physicians.

Charles H. Crownhart, secretary of the state medical society, a paid elected officer, said that the break with Blue Cross was made solely on the basis of economic factors and had nothing to do with the philosophy under which Blue Cross operates. In a May 9, 1958, report on Blue Cross, Mr. Crownhart told the state society's Council that "the greatest place where we are being overcharged today is in sales. They are charging us $180,000 a year. Now here is the absurdity of the situation. I go to . . . and I say, '. . . you are president of the company; I want you to buy Blue Cross,' and he buys it. So Blue Cross charges itself $.1142 for the installation, for putting that contract into effect.

"Then after I have sold him on the concept of Blue Cross, I say, now let's add to that policy, Blue Shield. That will help; that implements. So at that point the total cost becomes $.22. Perhaps I haven't made myself clear, but it can't cost twice as much to sell Blue Cross and Blue Shield as it does to sell Blue Cross only . . . I assert on the basis of our own studies that today Blue Cross is making $60,000 or better clear profit out of that phase of its contract."

Mr. Crownhart also said that Blue Cross was demanding payments for legal representation and other activities that Blue Shield did not want and that it was being charged a disproportionate rate for its share of the property taxes connected with Blue Cross' new headquarters building in Milwaukee.

George J. Nauert, assistant executive vice president of Associated Hospital Service, and A. H. Luthmers, assistant executive secretary of Surgical Care (Milwaukee Blue Shield), said that Mr. Crownhart used the cost issue as the means for breaking with Blue Cross and eventually would have found some way to break the agreement anyway (the cost issue was the only matter subject to negotiation in the self-perpetuating contract).

BILLING SYSTEM CRITICIZED

They also said Mr. Crownhart is against Blue Cross because it refuses to pay doctors directly for services which are billed through the hospital (radiologists, anesthesiologists, etc.).

Mr. Crownhart said that he had asked Blue Cross to run a very precise comprehensive cost accounting study on its operations to determine what expenses were really applicable to Blue Shield functions. Blue Cross refused to undertake the special study because of prohibitive costs.

Mr. Crownhart said he felt that the study had been rejected because it would show that his Plan had been overcharged and that inefficiencies in operation would turn up. He said that of the three plans involved in the controversy his is the only one operating in the black.

After the state Blue Shield Plan dropped Blue Cross (February 1958), the state Blue Shield Plan adopted a rider to its policy so that subscribers could buy hospital and medical care together. The Blue Cross Plan, at the time not having a medical plan to offer on a state-wide basis, established Health Insurance Corporation, a stock-for-profit corporation sanctioned by the state insurance commissioner. The nonprofit plans themselves are not under the insurance commissioner's jurisdiction; Wisconsin is one of 10 states where this is true.

Blue Cross reported that Wisconsin Physicians Service has incurred a net loss of 28,000 subscribers to Surgical Care or HIC since the WPS-Blue Cross split took place.

WPS, BLUE CROSS BILL SAME WAY

Under its hospital rider, WPS still pays hospitals for services for which the hospital does the billing (radiologists, anesthesiologists, etc.). Mr. Crownhart said that this system is being followed in recognition of the hospital-physician relationship that exists in many cases. He said he would like the system changed, but does not see such a change taking place soon.

Mr. Nauert said Blue Cross favored a system whereby diagnostic services would be billed through both Blue Cross and Blue Shield, with the hospital Plan paying for the hospital portion of the bill and the medical Plan paying for the medical doctor's portion of the bill.

Soon after the state society's dissociation with Blue Cross, the Blue Shield Plan in Milwaukee expanded to cover the 10-county Milwaukee "trading area." The county Plan later expanded to a state-wide operation after HIC was instituted. Although Blue Cross was meeting with success in selling HIC, the hospital Plan stated, it preferred to market a plan that belonged to doctors. Noting HIC's success, Dr. Morton stated in a letter to Milwaukee County medical society members, the Milwaukee Plan agreed to state-wide distribution in order to keep control of medicine in the hands of doctors.

When Surgical Care (Milwaukee) was begun in 1943, three years before the state society came up with its own Blue Shield Plan, it was marketed state-wide. After the state Plan went into effect, the county Plan accepted Milwaukee County as its sole sales territory.

Mr. Crownhart said that the county Plan was set up as an experiment of the state society and that the state group never intended to relinquish its claim to the whole state for selling Blue Shield. He said the county had only one account during its first years and that the county's program was underwritten by the state society.

He also said that the state society had the right, under state law, to pass the resolution restricting county medical societies from selling health insurance plans outside their own counties. Blue Cross and the Milwaukee Plan cited the same law to show that the state society had the power to approve the county Plan originally, but could not now withdraw its approval.

In 1946 the American Medical Association was called in to act as arbitrator during a similar controversy. AMA suggested that a new Blue Shield Plan be set up with new personnel from outside either the state or county societies. The new plan's headquarters office was to be located anywhere in the state except Milwaukee or Madison. The compromise was never effected. ■

SURGEONS HOLD CLINICAL MEETING—

Medical Education Advisory Group Set Up

"With the whole-hearted approval of [Health, Education, and Welfare] Secretary Arthur S. Flemming, I am inviting a group of national leaders in medicine, education and public affairs to serve as an advisory committee to the Public Health Service on medical education. Leaders from major medical groups . . . will be asked to serve, as well as representatives of related health professions, education and leaders in public affairs."

With these words Surgeon General Leroy E. Burney indicated the government's intention to take up the reins of an expanding program of medical education. Dr. Burney spoke at the 44th annual Clinical Congress of the American College of Surgeons held in Chicago Oct. 6-10.

"As a profession," Dr. Burney told the surgeons, "we have been on the defensive in issues tangential to the art and science of medicine and have adopted negative attitudes in solving social problems when a positive attitude and leadership were needed . . .

"We in the United States are falling behind in the race for medical manpower, month after month and year after year."

At the annual meeting, the medical profession was called upon to arrange a training program for ambulance attendants, the purpose of which would be improvement in the care of 10 million persons injured annually in the United States.

Calling attention to the problem was Dr. George J. Curry, chief of the Section for Surgery of Trauma, Hurley Hospital, Flint Mich., during his delivery of the 26th annual Oration on Trauma.

"If we are to expect maximum efficiency from ambulance attendants, a special training program must be arranged," he said. "The curriculum should include a discussion of illnesses and injuries ordinarily encountered, their emergency care and methods of transportation."

Dr. Curry also said that the few minutes saved in transporting an injured person at 60 miles per hour, compared with a speed of 30 miles an hour, is not justified as borne out by 2500 cases at Hurley Hospital. There is more danger for the injured person in the high speed, he said, than in taking five more minutes to arrive at the hospital.

Dr. William R. Laird, from Montgomery, W. Va., and Dr. E Payne Palmer Sr., from Phoenix, Ariz., were presented with the college's distinguished service award. Dr. Laird endowed and established the Laird Memorial Hospital, Montgomery, W. Va., which he later donated to the Laird Foundation Inc., a nonprofit organization founded for relief of suffering and advancement of medical education and research. Dr. Laird

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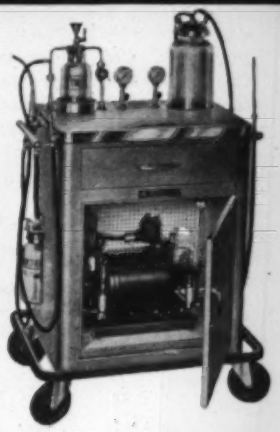

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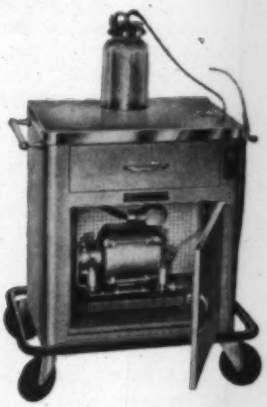

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Equipped with 1-gallon suction bottle and recessed suction gauge. *Printz* Model, Cat. No. 100-85 (not illustrated) has a 32-ounce ether bottle in addition to the 1-gallon suction bottle.

Printz Model, Cat. No. 100-87 (not illustrated) is same as 100-85 but equipped with separate rotary compressors for ether bottle and suction bottle.

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Complete with 32-ounce suction bottle, 16-ounce ether bottle, two-way by-pass valve and spray tube. Sklar Pump Table, Cat. No. 100-40 (not illustrated) mounted on conductive rubber casters, complete with utility drawer, shelf and rack for sprays and sinus cleanser. Tompkins Model for suction only, Cat. No. 100-15 (not illustrated) is equipped with two 32-ounce suction bottles and no ether bottle.

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also founded the Summersville (W. Va.) Clinic, which operates in conjunction with the hospital through the foundation.

Dr. Palmer, 82, was a founder fellow of the college and an originator of its program of hospital standardization. He was a governor of the college for 28 years.

Dr. Owen H. Wangensteen, chairman of the department of surgery, University of Minnesota Medical School, Minneapolis, was named president-elect of the college.

Dr. Newell W. Philpott, emeritus professor of obstetrics and gynecology, McGill University Faculty of Medicine, Montreal, was installed as president of the college. Dr. Philpott is also honorary consultant for the Royal Victoria Hospital, Montreal, Jewish General Hospital, Montreal, and Physicians' Hospital, Plattsburgh, N.Y. ■

Groups Elect Officers

Montana Hospital Association: president, Robert Howe, administrator, Billings Deaconess Hospital, Billings; president-elect, Sister Mary Thomas More, administrator, St. Josephs Hospital, Lewistown; vice president, C. T. Holland, administrator, Broadwater Hospital, Townsend; secretary-treasurer, Dr. William B. Talbot, administrator, Butte Community Memorial Hospital, Butte.

American Society of Hospital Pharmacists (to be installed at the group's annual convention during the week of April 19, 1959): president-elect, William Heller, chief pharmacist, University of Arkansas Medical Center, Little Rock; vice president-elect, Vernon Trygstad, director of pharmacy service, Veterans Administration Department of Medicine and Surgery, Washington, D.C.; treasurer-elect, Sister M. Berenice, director of pharmacy service at the St. Mary's group of hospitals of St. Louis University, St. Louis.

Southeastern Society of Hospital Pharmacists: president, Gilbert Colina, chief pharmacist, Mercy Hospital, Charlotte, N.C.; vice president, Perry W. Cox, chief pharmacist, Carraway Methodist Hospital, Birmingham, Ala.; secretary-treasurer, Mary Wernersbach, chief pharmacist, Mt. Sinai Hospital, Miami Beach, Fla. ■

State Association Presidents

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Community Hospital
Long Beach

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Jackson County Hospital
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RALPH R. BETTS
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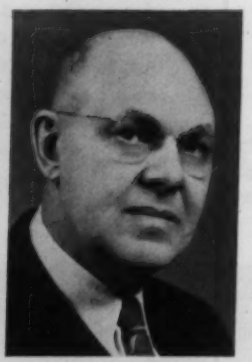

L. WADE COBERLY
Administrator
Davis Memorial Hospital
Elkins

Medical Care Costs Continue At Head of U. S. Price Index

Medical care continued to be the highest single category in the consumer price index, according to statistics released on August prices by the U. S. Bureau of Labor Statistics.

Medical care was up .4 per cent in August (to 145) compared with July. The average for the years 1947-49 equals 100. The next highest category on the index was transportation at 141.

The rise in medical care, the bureau stated, reflected higher premiums for group hospitalization insurance in three small cities, higher fees for professional and hospital services, and increased prices for prescriptions and drugs. ■

Blue Cross Hospital Care Expenditures Hit New High

An all-time high in expenditures for hospital care for Blue Cross subscribers was recorded during the first six months of 1958 by the 83 approved Blue Cross Plans. The announcement was made by the Blue Cross Commission.

More than $690 million of total income was expended for hospitalization costs. U.S. Plans spent $647,952,286, or 100.45 per cent of income, for hospitalization care. Canadian Plans spent $42,055,591, or 97.12 per cent of income, for hospitalization care.

The percentage of operating expense reached a new low, the Commission reported, with 5.92 per cent of total income expended for this purpose. Operating costs of U.S. Plans during the first six months of 1958 represented 5.99 per cent of their total income, compared with operating costs of 6.04 per cent for the first six months of 1957. Operating costs for Canada represented 4.85 per cent of total income, the Commission stated, compared with 5.47 per

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cent for the same period a year ago.

During the second quarter of 1958, reserves of U.S. Plans dropped 6.44 per cent of total income, compared with a 2.07 per cent decrease for the second quarter of 1957. Reserves for Canadian Plans also dropped, decreasing by 1.97 per cent of total income, compared with a .75 per cent increase during the same period in 1957. ■

Hospitals Defend Blue Cross In Grand Jury Investigation

Hospital administrators in many parts of South Carolina have come to the defense of Blue Cross, following a recommendation by an Orangeburg, S.C., grand jury that discounts by hospitals to Blue Cross for bills paid on behalf of Plan subscribers be discontinued.

The grand jury recommendation was made during investigation of charges concerning rising costs at Orangeburg (S.C.) Regional Hospital.

If the practice of allowing discounts to Blue Cross is not discontinued, the grand jury recommended, legislative action should be taken. The grand jury found that charges for service at the Orangeburg Regional Hospital were essentially the same as those in other hospitals.

In calling for discontinuance of the discount policy, the grand jury stated that "of course any discount given Blue Cross has to be made up by other patients . . ."

BUSINESS PRINCIPLES DEFENDED

Charles C. Boone, in a statement after announcement of the jury's recommendation, said that hospital-Blue Cross monetary arrangements are based on sound business principles and do not penalize patients who are not members of the Plan. Mr. Boone is president of the South Carolina Hospital Association and administrator of Barnwell (S.C.) County Hospital.

He said the financial arrangements are "based on the sound business principle that it costs a vendor less to sell a carload of merchandise than to sell the same merchandise piece by piece.

"Bulk sales of a product reduce bad debt losses, reduce collection expenses and reduce clerical costs. The net result of these savings is that it costs hospitals less to provide care for Blue Cross subscribers than to the average self-pay patient.

H. E. Hamilton, administrator of Spartanburg (S.C.) General Hospital, said Blue Cross is important to hospitals because "we are assured a spot cash payment" on all allowances for which Blue Cross has agreed to pay and "we do not have to worry about collections allowed because this plan is . . . unassignable except to the hospital."

DISCOUNT LIMITS

Ray Everett, assistant administrator of Roper Hospital, Charleston, S.C., said that contrary to the jury's report "Blue Cross does not receive a discount on all bills paid by them to South Carolina hospitals. A discount is given on bills for hospitalized inpatients with the exception of hospitalized diagnostic cases. Also no discount is given on bills for outpatient services to nonhospitalized patients.

The *Orangeburg Times and Democrat*, in an editorial expressing confidence in the management of the Orangeburg Regional Hospital, stated: "since our hospital is a nonprofit operation, the charges to Blue Cross are full charges, for every penny of actual cost. Since the amount is collected fully, without any losses due to nonpayments, etc., the hospital actually realizes more money from this 49 per cent of its patients [those having Blue Cross policies] than it does from the other 51 per cent, who are not under Blue Cross." ■

Advisory Committee Named To Assist New AHA Service

The American Hospital Association has appointed an advisory committee to its newly created Community Relations Service for Hospitals.

MR. SUTPHEN

Dr. Edwin L. Crosby, director of the Association, said the committee, with Duncan D. Sutphen Jr., New York City, chairman of Materials Development, as chairman, will include: George Bugbee, president of the Health Information Foundation, New York City; Alfred S. Dashiell, managing editor of the *Reader's Digest;* Ray Mackland, picture editor of *Life* magazine, and John H. Tinker Jr., senior vice president of McCann-Erickson Inc., New York City, advertising agency. Daniel S. Schechter, chief of the Public Information and Education Division of the American Hospital Association, is also a member of the committee and will serve as its secretary.

MR. DASHIELL

MR. BUGBEE

MR. MACKLAND

MR. TINKER

The Community Relations Service will provide graphic arts materials and other public relations aids for use by hospitals and their communities. Dr. Crosby said it was anticipated that the service would be made available for use in hospitals in 1959.

The project will be financed initially by funds allocated by the Hospital Research and Educational Trust, an independent organization created by the American Hospital Association for research and educational activities. Continuation of the program will be supported by nominal subscription fees from hospitals which use the service.

Mr. Sutphen, whose appointment as chairman of Materials Development was announced in May, has been associated with the hospital field since 1942 and is currently president of the board of Phelps Memorial Hospital, North Tarrytown, N.Y. He was for many years president of the Gotham Advertising Co. in New York City and has offices at 342 Madison Ave., New York City. ■

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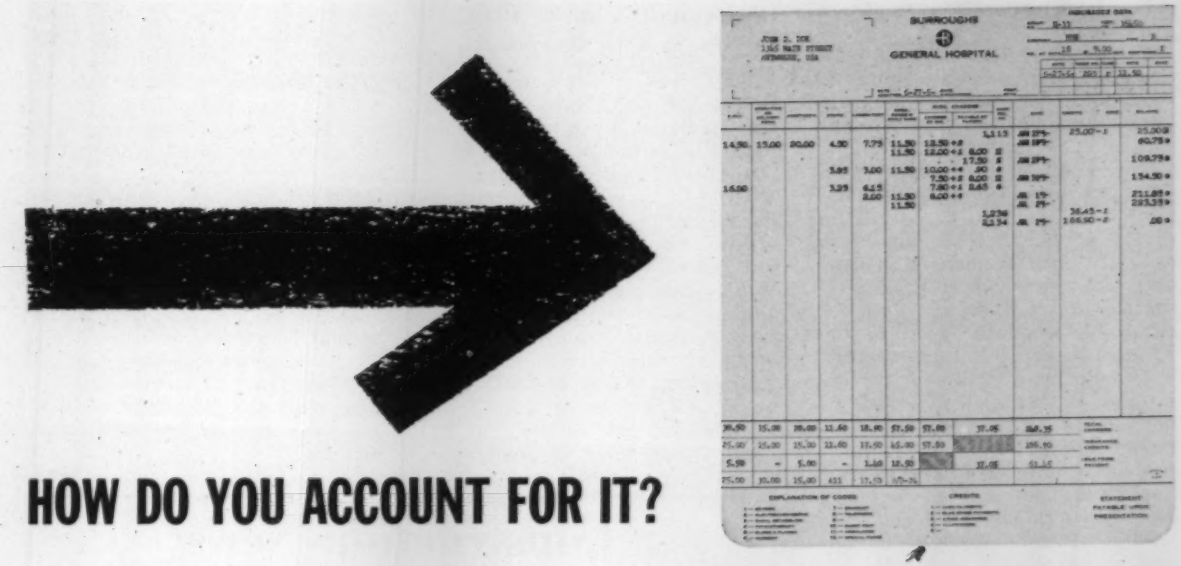

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To gain the effect of group participation, the insurance policy is being sold for a limited time in Illinois, Indiana, Iowa, and Wisconsin only.

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The policy immediately covers hospital or surgical treatment of any injury or disease for which prior medical advice or treatment had not been received and all accidents and sickness after the policy has been in force for six months.

Although individual policies cannot be canceled, Continental has reserved the right to cancel the entire program for all who purchase the policy if experience in the category of coverage is poor.

Blue Cross Plans now have approximately one-third, or five million, of the over-65 age group enrolled in their Plans. ■

Air Force Gen. Armstrong Retires After 30 Years

Major General Harry G. Armstrong, Air Force medical corps, has retired after almost 30 years of military service. He was Air Force surgeon general from December 1949 to June 1954.

GEN. ARMSTRONG

Gen. Armstrong was a pioneer in aviation and space medicine and is the author of "Principles and Practices of Aviation Medicine," a standard textbook on aviation medicine in use throughout the world. As commandant of the Air Force School of Aviation Medicine, Gen. Armstrong established the first Department of Space Medicine.

He has been the recipient of numerous awards from the U.S. government, universities, and professional organizations concerned with aviation and medicine. Gen. Armstrong holds fellowships or honorary fellowships in 11 professional aviation and medical organizations and has been honored by six foreign governments for his work. ■

Retirement Annuity Plan Begins at Two Hospitals

Employees at Southern Baptist Hospital, New Orleans, and Baptist Memorial Hospital, Jacksonville, Fla., are now covered by a retirement annuity program.

The program was approved by the board of directors that operates the two institutions and went into effect July 1, Raymond C. Wilson, Southern Baptist Hospital administrator, reported.

All full-time employees 30 years of age or more, with at least three full years of service and who were on the payroll as of July 1 are eligible for participation in the plan. Other full-time employees will become eligible for participation on the July 1 after they meet the eligibility requirements.

The hospitals will pay for the entire cost of the program for all employees whose annual salary is not more than $6000. The cost to those with salaries of more than $6000 per year is computed at the rate of 6.5 per cent of the annual salary in excess of $6000. Contributions are being handled on a payroll deduction basis.

Employees become eligible for normal retirement income at age 65, although an employee with 10 or more years of service may retire, with the hospital's consent, any time after he reaches his 55th birthday. ■

Construction News

CALIFORNIA

San Diego—Sixty-two bed Doctor's Hospital is nearing completion. The estimated construction cost is $800,000.

CONNECTICUT

Bridgeport—A $450,000 addition at St. Vincent's Hospital is nearing completion.

New Haven—Construction has begun on the 50-bed Municipal Convalescent Home. Estimated construction cost is $381,788, with a total of $445,000 estimated for the whole project.

Wallingford—Masonic Home and Hospital is spending an estimated $180,000 on a remodeling program which is to add 40 beds to the institution's capacity. As part of the program there will also be complete new medical facilities, oper-

Architect: Rogers and Butler

CONSTRUCTION of a 2-story building to house New York Hospital's outpatient department, emergency department, and part of the radiology facilities, has begun. A campaign to raise $8 million for construction and endowment of the new building, named in honor of Dr. Connie Guion, a member of the hospital's medical staff for 40 years, has been launched by the hospital. The new unit is the first major structural addition to the main hospital since the New York Hospital-Cornell Medical Center was built in 1932. Foundations are being constructed to allow for future additional stories if needed. Large areas of glass have been incorporated into the design of the limestone facade to shed light on the waiting rooms. Thin prefabricated metal partitions will allow flexibility in the use of floor space, enabling rapid changes in the layout to accommodate changing space requirements. The entire structure is to be centrally air-conditioned and equipped with acoustical ceilings and fluorescent lighting. Modernization and coordination of the hospital's semiprivate and pavilion admitting departments are to take place.

FIRE at Signal Hill

May 22, 1958. Suddenly, clouds of inky smoke and roaring towers of flame boiled up from an oil refinery near Long Beach, Calif. Wholesale death and injury seemed a certainty. Fortunately, casualties were light.

But, Long Beach already was preparing for any *community* catastrophy as well as the everyday health emergencies confronting families of any typical American City.

Months before, the hospital administrators had surveyed their facilities and embarked upon an extensive expansion and modernization program. They called in AMERICAN CITY BUREAU to organize and direct a United Hospitals Appeal. The goal–$4,000,000. The amount raised–$4,000,000 and more. Ample funds for the up-to-date equipment and facilities essential to better service under *any* condition.

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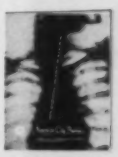

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ating room, laboratory, drug room, examination rooms, physical therapy department, and nurses work rooms.

FLORIDA

Bartow—A $600,000 addition and remodeling program at Bartow Memorial Hospital, which is to add 79 beds to the hospital, is nearing completion.

ILLINOIS

Evanston—Nearing completion at Evanston Hospital is a $5 million addition and remodeling program, which is to add 190 beds to the hospital's capacity.

Rosiclare—Twenty-five bed Hardin County General Hospital is nearing completion. The new hospital, which is being constructed so that it can be expanded to 32 beds, is to cost an estimated $630,000.

INDIANA

Salem—Washington County Memorial Hospital is nearing completion of its addition and remodeling program. The project, to cost an estimated $500,000, will add 43 beds to the hospital.

LOUISIANA

Natchitoches—Work is being completed on 62-bed Natchitoches Parish Hospital. The unit is being built at an estimated cost of $1 million.

MASSACHUSETTS

Bedford—A 180-bed admission and treatment building is being built at the Veterans Administration Hospital at an estimated cost of $2.8 million.

Gloucester—An $855,000 addition to Addison Gilbert Hospital is nearing completion. The new unit is to have 36 beds, and laboratory, x-ray, and operating room facilities.

MICHIGAN

Kalamazoo—Remodeling at Bronson Methodist Hospital is nearing completion. The project, which will make 50 beds available for chronic illness patients plus adding a rehabilitation center, is to cost an estimated $404,000.

Pontiac—Pontiac General Hospital will have 330 beds after its $5 million remodeling project, presently under way, is completed.

Tecumseh—A $300,000 addition at Herrick Memorial Hospital is to contain 25 beds, a new kitchen, and an employee's lounge.

MISSOURI

North Kansas City—North Kansas City Memorial Hospital was recently completed at an estimated cost of $1.2 million. The new facility has 80 beds. A 20-bed addition was completed after the main unit was put into operation.

MONTANA

Billings—A $1,150,000 addition and remodeling program is under way at St. Vincent's Hospital. Twenty-eight beds and laboratory, surgery, outpatient, and rehabilitation facilities are being added.

NEW YORK

New York—Fifty-bed New York Foundling Hospital is being constructed at a cost of $8 million.

OHIO

Dayton—Under construction at Dayton Children's Psychiatric Hospital is a 100-bed childrens' psychiatric unit. The estimated cost is $1.5 million.

Toledo—Toledo State Hospital is nearing completion of a 100-bed addition to the institution's receiving hospital and therapy unit. Estimated cost of the project is $500,000.

OKLAHOMA

Oklahoma City—Some $40,000 is being spent to add a dietary department to St. Vincent's Home for the Aged.

OREGON

Salem—Salem Memorial Hospital is building a $675,000 addition to contain a receiving department, x-ray unit, central service section, laundry, psychotherapy equipment,

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Emory University

MOIR P. TANNER
Director, Children's Hospital
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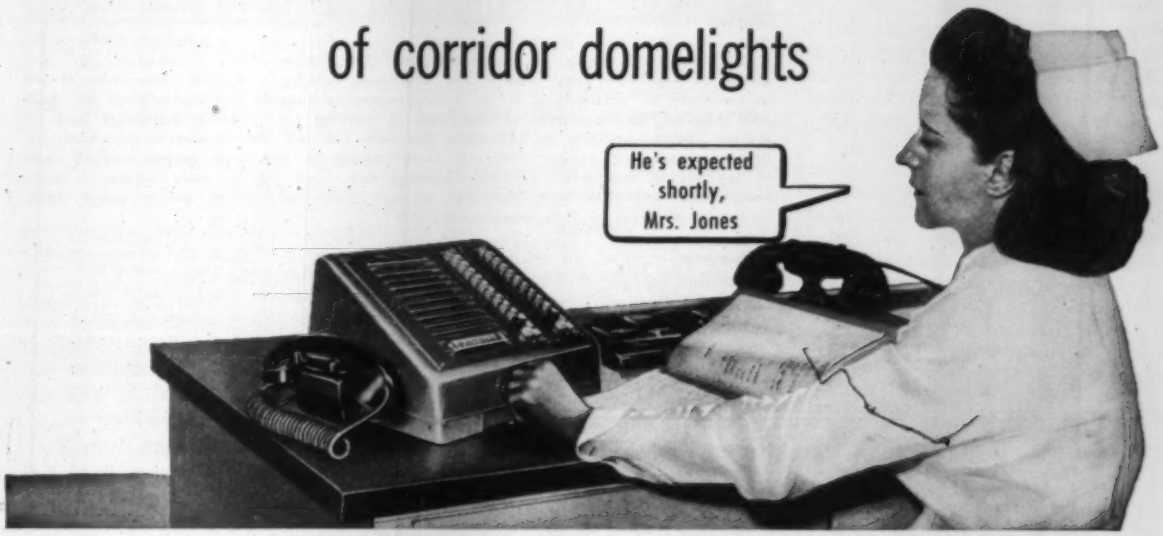

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PENNSYLVANIA

Philadelphia—Ninety-bed Juniata Park Medical Center and Hospital is being constructed at a cost of approximately $600,000.

Scranton—Some 150 beds are being added to Mercy Hospital at an estimated cost of $2.1 million.

Sellersville—A 60-bed addition is under construction at Grandview Hospital. The addition, to cost an estimated $900,000, will also contain operating suite, administrative offices, laboratory facilities, and a new boiler house and heating system.

West Chester—Twenty beds for psychiatric inpatient care of children will be added to Oakbourne Colony Hospital during the remodeling program there. Cost of the project is approximately $270,000.

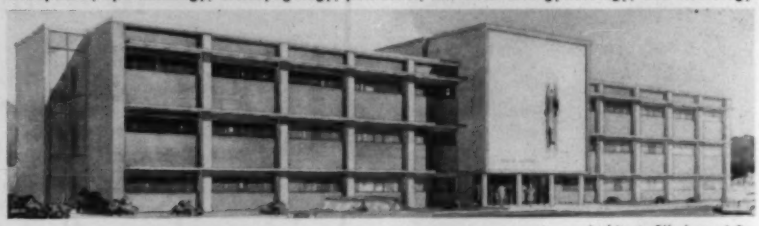
RHODE ISLAND

Providence—Providence Lying In Hospital is adding 75 beds and ancillary services in a $2.1 million addition and remodeling program.

TEXAS

Houston—Construction is being completed on a $795,000 addition at the University of Texas M.D. Anderson Hospital and Tumor Institute.

A NEW Air Force hospital was recently completed at Scott Air Force Base, Ill. The five-story reinforced concrete structure is air-conditioned and has 250 beds. The hospital is expandable to 500 beds by the addition of another wing. It is a tuberculosis and thoracic surgical center for the Air Force Medical Service. Its other services include general medicine and surgery, orthopedics, opthalmology, otolaryngology, pediatrics, obstetrics and gynecology, and neurology.



Architect: Ellerbe and Co.

A $1.1 MILLION addition to Carle Hospital Clinic, Urbana, Ill., is scheduled for completion in mid-1959. Total area of the 3½ story building is 47,500 square feet. It will be connected by passageway to the medical-maternity hospital and the surgical and pediatric hospital building now on the site. A parking lot is being expanded from its present 350-car capacity to 550 cars. The new unit will be completely air-conditioned. Gravity chutes and vertical lifts will carry records to and from various control desks to the record department. Exterior surfaces are brick, glass, and concrete columns. Thirty-seven physicians are planning to rent the new facility on a group basis.

VIRGINIA

Hopewell—Some 39 beds are being added during an $845,000 addition and remodeling program at John Randolph Hospital.

Newport News—Whittaker Memorial Hospital is adding 30 beds during its addition and remodeling program. Estimated cost of the project is $722,000.

Norfolk—Facilities for 67 beds, 35 pediatric and 32 medical and surgical, are under construction at DePaul Hospital. The addition and remodeling project is to cost approximately $1.4 million.

WASHINGTON

Seattle—A 25-50 bed unit, to cost more than $700,000, is under construction at Seattle General Hospital. Surgical facilities will also be included in the addition.

Tacoma—Madigan Army Hospital is undergoing an addition and remodeling campaign which will add a 23-bed recovery ward and physiotherapy clinic at an approximate cost of $143,395.

WISCONSIN

Hartford—St. Joseph's Hospital is undergoing a remodeling program which is to add 20 beds to the hospital's facilities and enlarge its services. Estimated cost of the project is $928,000.

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Hospital association meetings

(Continued from page 6)

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(THROUGH DECEMBER 1958)

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Nursing Service Administration—November 3-7; Philadelphia (Bellevue-Stratford Hotel)

Physical Therapy—November 10-14; Kansas City, Mo. (Bellerive Hotel)

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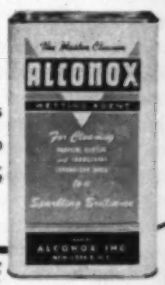

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Methods Improvement—December 1-3; Denver (Cosmopolitan Hotel)
"Staffing" Departments of Nursing — December 8-11; Chicago (Shoreland Hotel)
Hospital Housekeeping — December 8-12; Los Angeles (Ambassador Hotel)

Ordered definitions

(Continued from page 46)

either by a specialty field of medicine or by a specific category of disease.

There will be no difficulty in extending this definition, as in the case of special hospitals, to cover such special parahospitals as are exemplified by the following:

An OBSTETRICAL (MATERNITY) PARAHOSPITAL is a parahospital with its services (including those of obstetrical delivery) directed wholly or chiefly to obstetrical patients.

A PSYCHIATRIC (MENTAL) PARAHOSPITAL is a parahospital with its services directed wholly or chiefly to psychiatric patients. (Examples: "senile" parahospitals, "mentally defective" parahospitals.)

An EPILEPSY PARAHOSPITAL is a parahospital with its services directed wholly or chiefly to epileptic patients.

A CANCER PARAHOSPITAL is a parahospital with its services directed wholly or chiefly to cancer patients.

HOSPITAL OR PARAHOSPITAL?

Perhaps the most crucial test of the system of patient centers as defined herein rests in its potential to differentiate the parahospital from the hospital. Two bases exist for arriving at this distinction; they may be used together or separately.

The first depends on the nature of the continual physician services and continuous nursing services essential to the hospital. "Continual physician services" implies that at least the management of the patient is under continued direction of the physician; "continuous nursing services" means that at least the nurses exercise continuous supervision of the patient. Such services must be performed for patients who require them or the "services" by definition are not services. In other words a parahospital cannot become a hospital by providing such

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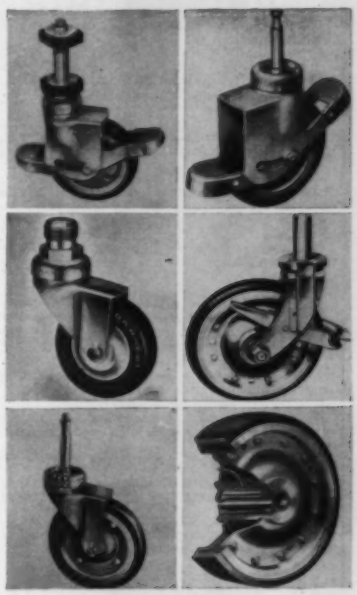

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OF HOSPITALS, published twice a month at Chicago, Ill., for Oct. 1, 1958.

1. The names and addresses of the publisher, editor, managing editor, and business managers are:

Publisher: American Hospital Association, 18 E. Division St., Chicago 10.

Editor: Edwin L. Crosby, M.D., 18 E. Division St., Chicago 10.

Managing editor: Aaron Cohodes, 18 E. Division St., Chicago 10.

Controller: John E. Sullivan, 18 E. Division St., Chicago 10.

2. The owner is: (If owned by a corporation, its name and address must be stated and also immediately thereunder the names and addresses of stockholders owning or holding 1 percent or more of total amount of stock. If not owned by a corporation, the names and addresses of the individual owners must be given. If owned by a partnership or other unincorporated firm, its name and address, as well as that of each individual member, must be given.)

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Ray Amberg, University of Minnesota Hospitals, Minneapolis 14, Minn. (Pres.).

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5. The average number of copies of each issue of this publication sold or distributed, through the mails or otherwise, to paid subscribers during the 12 months preceding the date shown above was: (This information is required from daily, weekly, semi-weekly, and triweekly newspapers only.)

JOHN E. SULLIVAN
Controller.

Sworn to and subscribed before me this 10th day of September, 1958.

[SEAL]

BEULAH DEEKEN
Notary Public.

(My commission expires February 19, 1962.)

services to patients who do not require them.

But suppose a patient center meets the criteria of continual physician services and continuous nursing services for patients who require them. Is this patient center by definition a hospital? If not necessarily so, what other factors remain to be considered? The second basis for differentiation helps us to answer these questions.

The hospital, and also the parahospital, must be classifiable as being general or special in accord with definitions of the system. A general parahospital (with "its services devoted to patients who, collectively, have a variety of physical or physical and mental conditions") would then have to provide the same services as a general hospital to be considered a general hospital. The general parahospital would have to include services for "internal medicine, general surgery or complicated obstetrical delivery, and x-ray and clinical laboratory". Further, the general "parahospital" could not qualify as a hospital by claiming to be a special hospital since the character of its patients (those who "collectively have a variety of physical or physical and mental conditions") has already been, or may easily be, established.

Similarly, special hospitals include services and characteristics stipulated in the definitions which exceed those of a special parahospital. For example, a maternity hospital includes services for complicated obstetrical delivery. These would not be found in a maternity parahospital.

Consider also as an example the distinction between hospital and parahospital in the specialty-field of internal medicine. Remembering always that "when services are called for, it follows that facilities for those services must be present", we have stipulated in the definition for the internal-medicine hospital that x-ray and clinical laboratory services must be included. The internal-medicine parahospital is not required to have these services.

The category of patient centers currently labeled "chronic disease and convalescent hospitals" was selected as an excellent one on which to test efficacy of the definitions in differentiating between parahospitals and hospitals. California was again chosen as a state with a representative population of hospitals. The following sources of information were used to assemble needed data: the 1957 *Guide Issue* of HOSPITALS, JOURNAL OF THE AMERICAN HOSPITAL ASSOCIATION; the files of the Association's Hospital Information Bureau; the files of the Hospital Research and Educational Trust's research project "The Operation of Hospital Planning and License Laws;" and verification where available through source material of the California Department of Health.

The results of this investigation were as follows:

- 22 hospitals in California are listed as chronic and convalescent hospitals in the Guide.
- 14 of these 22 are parahospitals by our definition.
- Of the remaining 8, one is now out of operation, one is in fact a unit of a general hospital, and one has since become a short-term general hospital. One of the residual five provides services for surgery, conforming to the definition of a general hospital; another is a long-term children's general hospital; and the last three are long-term, internal-medicine hospitals.

It will have been noted earlier perhaps that the term "chronic disease hospital" is missing from the system we propose. It is natural to assume that acute and chronic are definitive terms for conditions and therefore the description of a hospital as an acute general hospital or a chronic disease hospital refers specifically to the types of conditions treated in such hospitals. However, acute general hospitals provide services for many chronic conditions as well as their exacerbations. Also, many "chronic disease hospitals" as presently called provide services for the acute phases of many conditions.

The terms acute and chronic when used in describing hospitals have in reality both become words of very loose meaning associated mainly with the length of stay of patients in the centers of reference. It is our reasoning that acute and chronic should remain descrip-

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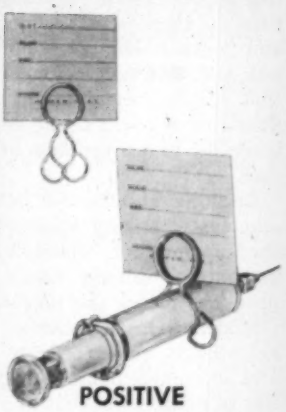

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tive of condition, and that the growing tendency to use short-term and long-term as descriptive of the usual length-of-stay element is commendable. The so-called "chronic disease hospitals" are classified in the system presented here as *long-term general hospitals* and *long-term special hospitals* depending on the services provided and the conditions handled.

REHABILITATION . . .

Although there is a specialty field of medicine known as "physical medicine and rehabilitation," rehabilitation is more appropriately an overlay to the patient-center system. Rehabilitation can occur and be planned for in *any* patient center. More important is the fact that rehabilitation involves more than medical (physician and paraphysician) services; it very properly includes also psycho-social and vocational or educational services. Indeed there may be only incidental medical services in a rehabilitation center, or even none at all. Because of this we believe that rehabilitation centers require their own system,[9] it being understood that their medical services when present will also qualify them as patient centers.

OUTPATIENT CENTERS

The following definitions for outpatient centers seem not to need explanatory comment except for one point. Such centers may be freestanding or parts of other patient centers. But this is not per-

9. The following is a tentative system of definitions for rehabilitation centers.
A REHABILITATION CENTER is an establishment with permanent facilities and two or more of the following services directed wholly or chiefly to patients or disabled persons in a program of rehabilitation: medical services, psycho-social services, and vocational training or educational services.
A PATIENT REHABILITATION CENTER is a rehabilitation center with its medical (physician and paraphysician) and psycho-social services directed wholly or chiefly to patients in a program of rehabilitation.
A TRAINEE REHABILITATION CENTER is a rehabilitation center with its psycho-social and vocational or educational training services directed wholly or chiefly to disabled persons in a program of rehabilitation.
A COMPREHENSIVE REHABILITATION CENTER is a combination of a patient rehabilitation center and a trainee rehabilitation center.
An INPATIENT REHABILITATION CENTER is a patient rehabilitation center with its services directed wholly or chiefly to inpatients in a program of rehabilitation.
An OUTPATIENT REHABILITATION CENTER is a patient rehabilitation center with its services directed wholly or chiefly to patients who receive no lodging in a program of rehabilitation.

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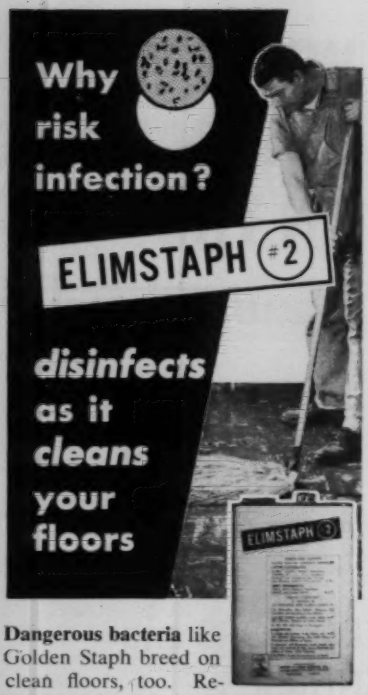

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tinent to necessary description; the definitions apply equally well to either situation.

An OUTPATIENT CENTER is a medical establishment with permanent facilities and services (physician and paraphysician, or dental) for patients who are not given lodging in receiving those services.

A GENERAL OUTPATIENT CENTER is an outpatient center with physician services and adequate paraphysician services, including x-ray and clinical laboratory, for patients who collectively have a variety of physical or physical and mental conditions.

A SPECIAL OUTPATIENT CENTER is an outpatient center with physician services and adequate paraphysician services for patients who collectively have conditions related either by a specialty field of medicine or by a specific disease category.

A DENTAL OUTPATIENT CENTER is an outpatient center with dentist and dental-aide services devoted to dental patients.

An OBSTETRICAL (MATERNITY) OUTPATIENT CENTER is a special outpatient center with its services, including clinical laboratory, directed wholly or chiefly to obstetrical patients.

A PSYCHIATRIC (MENTAL) OUTPATIENT CENTER is a special outpatient center with its services directed wholly or chiefly to psychiatric patients.

A PHYSICAL-MEDICINE OUTPATIENT CENTER is a special outpatient center with its services, including physical and occupational therapy, directed wholly or chiefly to physical medicine patients.

A PEDIATRIC OUTPATIENT CENTER is a special outptient center with its services, including x-ray and clinical laboratory, directed wholly or chiefly to pediatric patients.

An OPHTHALMOLOGICAL AND OTOLARYNGOLOGICAL (EYE, EAR, NOSE, and THROAT) OUTPATIENT CENTER is a special outptient center with its services, including x-ray and clinical laboratory, directed wholly or chiefly to ophthalmological and otolaryngological patients.

A CEREBRAL PALSY OUTPATIENT CENTER is a special outpatient center with its services directed wholly or chiefly to cerebral palsy patients.

A TUBERCULOSIS OUTPATIENT CENTER is a special outptient center with its services, including x-ray and clinical laboratory, directed wholly or chiefly to tuberculosis patients.

A PUBLIC HEALTH CENTER is a special outpatient center with its services, especially those of preventive medicine, devoted to the implementation of community health programs.

DEFINITION CONTINUES

The patient system of definitions will be extended in a sequel to this paper. The definitions for "patient", "inpatient", "newborn", and "outpatient" given herein are but the first in a longer series that will further highlight the emphasis on *services* as the key characteristic in our problem of definition.

Arriving at effective definitions and systematizing knowledge are the means for clarifying and, ultimately, solving many of the problems facing the hospital field. Confidence in a common factual knowledge prescribed by generally acceptable definitions is essential to progress in that knowledge. ■

Help for small hospital pharmacies

(Continued from page 59)

designed to help both the administrator and the pharmacist in becoming acquainted with the needs and demands of such a working relationship.

Material in the manual is based on regional conferences with hospital administrators and pharmacists and on a survey conducted by Professor Berman in 102 smaller hospitals in Michigan.

The University of Michigan College of Pharmacy plans to use the handbook in teaching senior pharmacy students who expect to practice in rural or outlying communities. The college also recommends the manual in the training of hospital pharmacists.

The manual contains such information as (1) kinds of drug orders pharmacists receive in hospitals, (2) special purchasing and inventory procedures, (3) basic drug stocks for nursing units, (4) medical terminology for the pharmacist, (5) safety factors and labeling methods, and (6) case studies of pharmaceutical services to smaller hospitals.

Single copies are available to administrators and pharmacists without charge from the College of Pharmacy, University of Michigan, Ann Arbor. ■

prn

PRO RE NATA

JOHN H. HAYES

It could be that the dress designer who started the sack dress style got the idea as a result of undergoing an operation. He saw the uniforms being worn by the operating room nurses.

★ ★ ★

Good maintenance men in hospitals are money savers. Expert carpenters, plumbers, upholsterers, painters, etc. are "depreciation reducers," no matter what you pay them, even if you do not include depreciation in your bookkeeping.

★ ★ ★

With so many of us owning cars, individuals now occupy much more space than formerly, because we are in the cars a good part of the time: going to work, to our pleasures, etc. It is indeed fortunate that we are not buried in our autos. If we were there would eventually be nothing but cemeteries.

★ ★ ★

The earliest "hospital" dietitians were probably the nice ladies who cooked broths and other nourishments to bring to their neighbors' houses when sickness occurred.

★ ★ ★

Nothing seems to delay delivery of a letter better than a special delivery stamp.

★ ★ ★

Someday—if I live long enough—I am going to invent a comfortable bedpan.

★ ★ ★

If you eat like a horse you ought also to work like one.

★ ★ ★

Hospitals with schools of nursing would have no financial worries if every employer of the nurses they graduate paid such hospitals a small percentage of the nurses' salaries each year. Silly, of course, but why should sick people and philanthropy have to pay the cost of nurse education?

★ ★ ★

SNAKE HOLLOW HOSPITAL NOTES: Zack Merkin, after his first hospital stay in his 89 years, said, on being discharged, "If I had known that a hospital is such a pleasant place to be I would have been in more often."

Mrs. Alma Sweetwater, president of our local garden club, who was a patient here from May until October, said, "I have been with you from jonquils to asters."

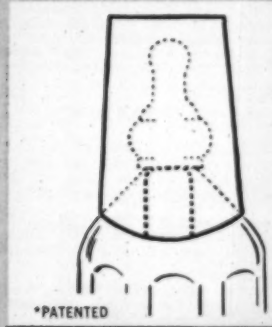
After our nurses' commencement exercises 60 per cent of the class announced their engagement. Someone has suggested that we print this fact in our student nurse recruitment prospectus as means of attracting more students.

The birds who built a nest in our TV aerial have now gone south for the winter. We wish the pigeons had the same idea.

★ ★ ★

Not so many years have elapsed since "blood letting" was considered a cure for many ailments. Now we give transfusions.

Remember...



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SERVICES

DISASTER PLANNING consulting service to aid your industry or institution to prepare plans of action in case of fire, flood, natural disaster or civil defense situations. Timothy G. Stillman, P.O. Box 54B, Cornwall-on-Hudson, New York.

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Investment syndicate is interested in purchasing proprietary profit making open staff hospitals anywhere in the United states. Will retain present personnel and maintain high standard public and patient relations. Unlimited cash available. All replies will be held in strict confidence. Address HOSPITALS, Box I-25.

POSITIONS OPEN

(a) DIRECTOR OF NURSING: Administer and coordinate work of nursing service and school of nursing. Prefer masters degree in education or administration with successful experience. (b) ASSOCIATE DIRECTOR OF NURSING: in charge of school of nursing. Prefer masters degree in education but BS acceptable if accompanied by proven ability. JCAH accredited, non-sectarian hospital of 576 beds including 125 non-acute beds and NLN accredited, diploma school of 160 students. University affiliation for basic sciences. Excellent salary, personnel policies and working conditions. Furnished apartment at reasonable rent is available. City of 110,000 located in year round recreational area. Write Personnel Director, St. Luke's Hospital, Duluth 11, Minnesota.

DIETITIAN: Therapeutic; with some administrative and supervisory work; and to help maintain patient contact; open now; good salary; 40 hour week; 4 weeks vacation; professional laundry furnished; 273 beds and 43 bassinets; approved; no school of nursing. Apply Miss Fern Brown, Director of Dietetics, Reid Memorial Hospital, Richmond, Indiana.

DIETITIAN: Opening in 400 bed hospital which is adding 120 bed rehabilitation unit. Excellent opportunity in therapeutic or administrative work for A.D.A. registered person. Salary commensurate with training and experience. Liberal benefits. Apply Personnel Director, Iowa Methodist Hospital and Raymond Blank Memorial Hospital for Children, Des Moines, Iowa.

ASSISTANT DIRECTOR, OCCUPATIONAL THERAPY — Modern tuberculosis hospital with affiliation program. Five day week, 40-hour, paid vacations, 7 holidays, sick leave, social security. Excellent opportunity for progressive administrator. Resume to Director, Occupational Therapy, Emily P. Bissell Hospital, 3000 Newport Gap Pike, Wilmington 8, Delaware.

REGISTERED NURSES: For a 201 bed University Hospital. Starting Salary $270-$285, rotating shifts with pay differential. 40 hour week add other liberal policies. Write; Director of Nursing, University of Nebraska College of Medicine; 42nd and Dewey, Omaha 5, Nebraska.

OUR 62nd YEAR

WOODWARD MEDICAL PERSONNEL BUREAU

FORMERLY A.NOE'S

185 N. Wabash-Chicago, Ill.

Telephone RAndolph 6-5682

ADMINISTRATORS: (a) Med or non-med; 600 bd med cntr; sevl units; req's expr, med schl affild hosps; lge tchg prog; NE. (b) Med or non-med; new univ hosp, lge size; important univ cntr; very substantial; So.Atlantic. (c) 3 hosps, total'g 450 bds, fully-apprvd; one w/excl adm & publ rels exper; $15,000; twn 80,000, New Eng. (d) 300 bd, general, vol, fully-apprvd hosp; lge city, PacNW. (e) 240 bd, vol, genl, JCAH hosp; one of finest twns, 100,-000, Calif. (f) New, 150 bd hosp, serv'g clinic staffed by 50 men; tropical island, American dependency; $12-15,000. (g) 125 bd hsp, in planning stage; need adm's advice; resort area, warm climate. (h) 120 bd hosp, estab'd 1913; may add new wing; $7,000, Midwest. (i) Direct 60 bd hsp & act as consultant in opening 4 additional sml hsps; will dir each as they open; excl oppor achieve directshp—grp 10 hsps; So. Calif. (j) New, modern, genl 60 bd hosp; about $10,000, Northwest. (k) Small, genl hosp, estab'd '36; entails reorganization; $6,500; Midwest.

ASSISTANT ADMINISTRATORS: (1) Replace one resigned; req's grad HA course & exper; 600 bd, fully-apprvd hsp; $7-10,-000; univ city, E. (m) 200 bd, genl, vol, JCAH hsp; one exper'd Personnel wk; to $6,000; coll twn, Midwest. (n) Asst Dir & Controller; 275 bd, genl, vol, fully apprvd hsp, expndg 50 bds; sal open, minimum $6,000; lge city, New England.

ADMINISTRATIVE POSTS: (o) Credit Mgr; req's 3 yrs exper c & c; pref coll deg & acctng trng; supervise staff of 10; 250 bd, fully-apprvd hosp; to $6,000; coll twn 80,000, Mideast. (p) Adm pers & publ rels prog; 150 bd, genl, vol, JCAH hosp; to $6,500; nr lge univ city, Mideast (q) Purchasing Agent; 300 bd, fully-apprvd hosp, unit of 10 hsps; excl oppor advance; about $7,000; Midwest.

EXECUTIVE HOUSEKEEPERS: (a) Apprv'd gen hsp 200 bds; Fla resort loca. (b) Oppty reorg dept; 1 ass't; 300-bd vol gen hsp; $4800; MW univ ctr. (c) Fully apprv'd gen hsp 200 bds; historic city nr impor univ med ctr; SE. (d) Full chge dept in 350-bd gen hsp, also 3 affil residences; univ city, st. capital; MW. (e) Gen hsp 100 bds, est 1955; SW resort city 35,000. (f) Sm apprv'd ped hsp; sal incl 2-rm suite, full mtce; NYC vicin. (g) Gen hsp 200 bds; lge expan prog now being planned; sm twn nr lge, prog city; MW.

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Blanche L. Shay, Director

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Chicago 2, Ill.

EXECUTIVE PERSONNEL: (a) Business Manager. Southwest. degree in accounting or business administration. Large hospital $8400 plus lovely home on hospital grounds. (H-2462) (b) Personnel Director. Middle West. 275 bed hospital. 600 employes. $7200. (H-2346). (c) Assistant Business Manager. Southeast. 500 bed hospital. (H-2434). (d) Credit and Collection Manager. South. Resort Area. 50-bed hospital-new (H-2357). (e) Personnel Director. Southwest. 500 bed teaching hospital. (H-2195). (f) Purchasing Agent. East. 500 bed hospital. (H-2229). Accountant office manager. 100 bed hospital. Est. 60 bed expansion planned. (H-2226).

EXECUTIVE HOUSEKEEPERS: (a) California. 325 bed hospital 24 maids in department. (H-1175). (b) Southwest. 500 bed teaching hospital. (H-2192). (c) South. 375 bed hospital in city of 70,000. (H-1613). (d) East. Near Boston. 125 bed hospital. (H-2401). (e) Northwest. 275 bed hospital. 75 full time employes in department. (H-1973). (f) East. 400 bed hospital. New 600 bed hospital being built. Will be ready next year for occupancy. To $7500. (H-2247).

NOTE: We can secure for you the position you want in the hospital field, in the locality you prefer. Write for an application—a postcard will do. ALL NEGOTIATIONS STRICTLY CONFIDENTIAL.

THE MEDICAL BUREAU

M. Burneice Larson—Director

900 North Michigan Ave.

Chicago 11, Illinois

ADMINISTRATORS: (a) Med; 500-bed gen. hosp; E; $25,000. (b) Ass't med. dir; 450-bed gen. hosp; attractive city, outside US. (c) Ass't dir; 1000-bed hosp; pref. M.D. qual. dir. outpatient clinic; oppor. succeeding dir. upon his retirement within few years; med. school city, MW. (d) Ass't; Master's req; pref. 30-40 with min. 3 yrs' exp. as ass't lge hosp. or adm. small hosp; 375-bed gen. hosp., Calif. (e) Ass't; Master's Hosp. Adm., several yrs' exp. req; 600-bed gen. hosp; E; $7-$10,000. (f) New 40-bed mosp; Mexico. (g) Small gen. hosp; pref. woman RN; min., $5000 including penthouse apt; MW. H11-1

ANESTHETISTS: (a) Handle complete anes. small hosp; prosperous farm community; $8000 up; MW. (b) Staff; modern 200-bed hosp; Pac. NW; $6800. H11-2

DIETITIANS: (a) Manage dept. 50-bed mod. hosp; Gulf region, Fla; good sal. (b) Teach in busy med. ctr, NYC area; $4800 plus. H11-3

DIRECTORS OF NURSING: (a) Dir., male or female, 2000 bed psy hosp; to $9000, mtce, MW. (b) Dir., nrsg serv & school; 180-bed hosp; prog. city, So; $800-$10,000. (c) Dir., all graduate staff; lge specialty hosp commuting distance NYC; outstanding financial oppor; pref. grad. hosp. adm. course. H11-4

EXECUTIVE HOUSEKEEPER: Wealthy suburban home for retired businessmen; also act as ass't adm. MW. H11-5

EXECUTIVE PERSONNEL: (a) Controller; hosp. grp, 600 beds; univ. city, MW; up to $10,000. (b) Personnel & purchasing; grp of 62 hosps; $8-$10,000 resp; med. ctr, E. (c) Public relations dir; capable of conducting in-service training prog; 250-bed gen. hosp nr NYC. (d) Personnel dir; 500-bed gen. hosp; univ. city, Pac. Coast. (e) Ass't purchasing dir; 1000 bed tch'g hosp, E. (f) Food director; 550-bed hosp; near Philadelphia. H11-6

FACULTY: (a) Educational dir; est. in-serv. prog; prepare procedure manual; ideal Fla. location; top sal. (b) Instructors; adult vocational schools; $6600 up; MW. H11-7

RECORD LIBRARIANS: (a) Org. new record installation of So. Calif. med. ctr; above average sal. (b) Small friendly Ariz. hlth resort; 40-bed hosp; $400 start. H11-8

SUPERVISORS: (a) Outpatient; renowned hosp. outside US; English speaking personnel; mild ocean climate; $5000 up, transp. (b) OR, Central Serv, act as consultants in hsp planning; travel thruout US; $7500 expenses. H11-9

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OUR 62nd YEAR

WOODWARD MEDICAL PERSONNEL BUREAU

FORMERLY AZNOE'S

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ASSISTANT ADMINISTRATOR: AHA; BA, bus adm; MS, hsp adm; having completed res seeks assist admshp, East or SE; age 27.

EXECUTIVE HOUSEKEEPER: male; early 40's; some coll trng; 8½ yrs hskpg exp, lge facil; seeks similar posi; NE & Atlantic Coast pref, highly recom.

EXECUTIVE HOUSEKEEPER: early 50's; cons hotel, motel exp; past 2½ yrs, full chge dept, 300-bd hsp; W, SW pref.

EXECUTIVE HOUSEKEEPER: late 50's; coll grad; past 4½ yrs, ass't in lge gen hsp; seeks full chge posi, N.Engl pref.

MEDICAL RECORD LIBRARIAN: Consultant for several hospitals; presently available for post in Okla, Texas or Arkansas; member, Amer Assn of MRL's; last post, Chief MRL, 475 bed, California hosp, 4 yrs.

PATHOLOGIST: Board Elig, both branches; 3 yrs, med ofc, US Army; 3 yrs, Path res, excl 700 bd, univ hosp; presently Asst Prof; seeks post as Assoc Path in priv hosp w/facils for rsrch (tchg, if possible); numerous publications; middle 30's.

RADIOLOGIST: 4 yrs, priv, genl practice; complet'g 3 yrs, excl Rad res, wonderful univ hsp; seeks hosp post, So, SW, or Calif; immed avail; age 34.

THE MEDICAL BUREAU

M. Burneice Larson—Director

900 North Michigan Ave.

Chicago 11, Illinois

ADMINISTRATOR: Medical; 16 yrs' successful exp. as hosp. adm; FACHA.

ADMINISTRATOR: MHA; 4 yrs, assoc dir, 400-bed tch'g hosp; 6 yrs, dir, 225-bed hosp.

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RADIOLOGIST: training in rad., tch'g hosp; 3 yrs, priv. & hosp pract; Diplomate.

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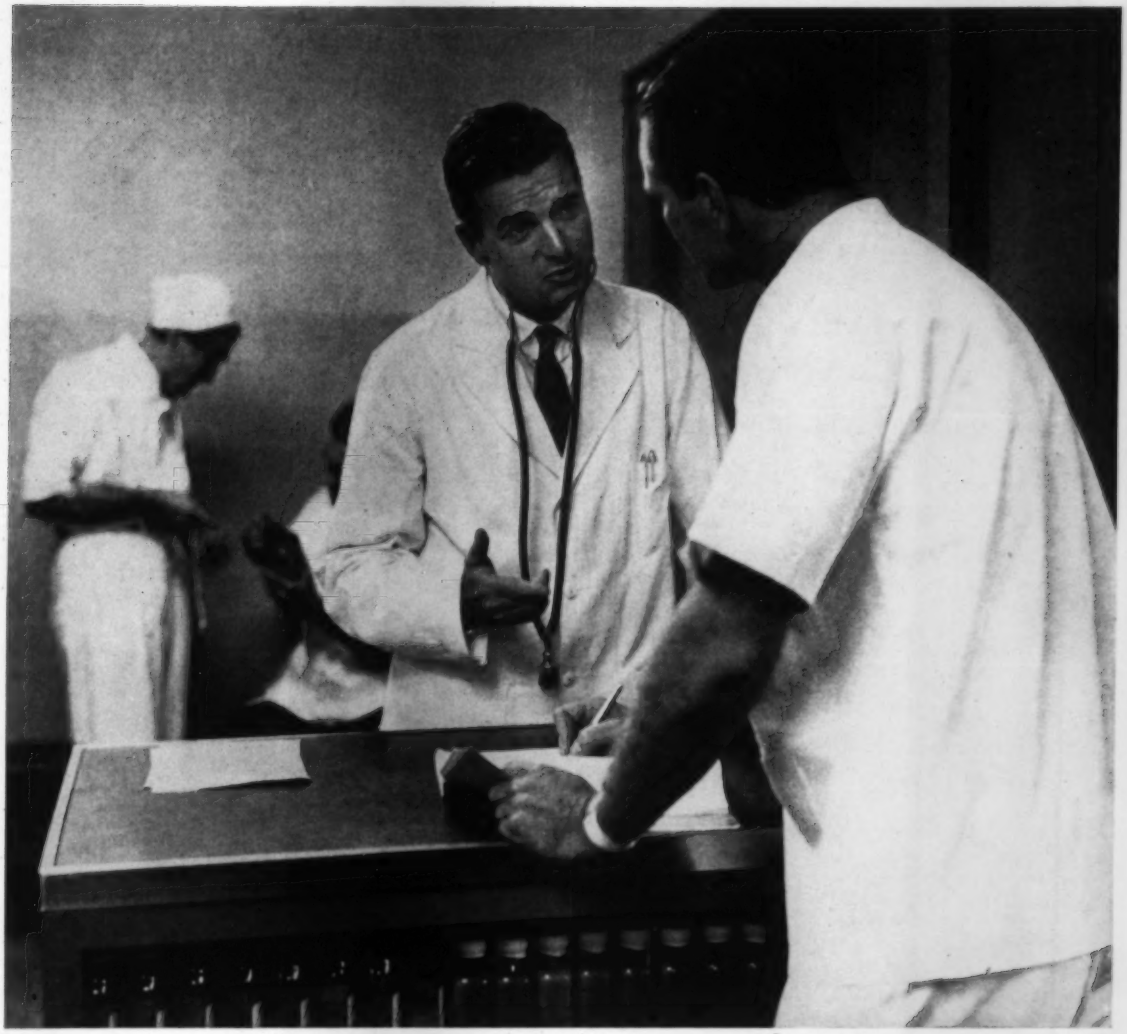

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1. Sher, D. B.: Aspirin and APC Irritation of the Stomach, Scientific Exhibit, World Congress of Gastroenterology; Washington, D.C., May, 1958.

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